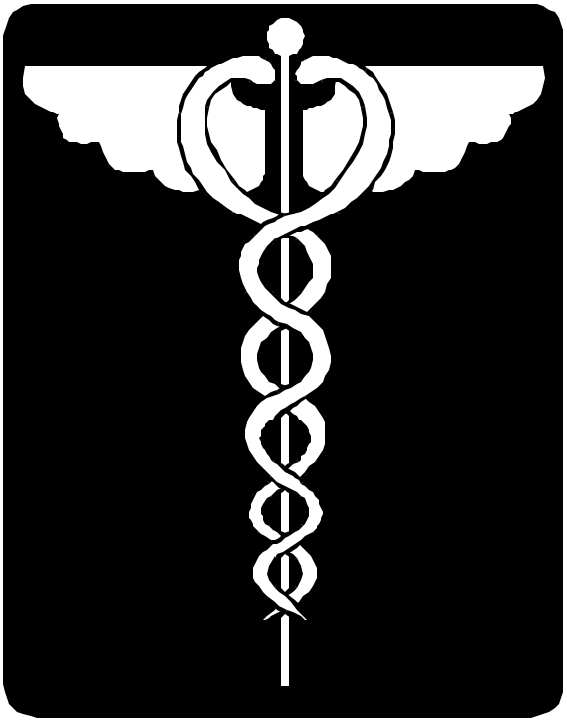
2006 Statewide Medical & Health Disaster Exercise

EXERCISE GUIDEBOOK and TOOLKIT

State of California
Emergency Medical Services Authority



NOVEMBER 15 & 16, 2006

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Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 15 & 16, 2006

Executive Summary

Dear Exercise Participant:

It is time again for the Statewide Medical & Health Disaster Exercise sponsored by the California Emergency Medical Services Authority (EMSA). This is California's eighth annual exercise incorporating hospitals and ancillary healthcare providers, including long-term care facilities and clinics, pre-hospital care providers, auxiliary communication networks, blood transfusion services, Emergency Medical Service (EMS) agencies, Public Health and other governmental agencies.

This year – in recognition of the 100 year anniversary of the 1906 San Francisco Earthquake and working in collaboration with the California Office of Homeland Security's Golden Guardian Exercise 2006 (GGEX06) - the Statewide Medical & Health Disaster Exercise Planning Committee has designed the scenario to build on the issues and challenges that will confront the State should a large-scale earthquake hit the San Francisco Bay Area, requiring mutual aid from all other regions in the state. There will also be a smaller component highlighting the Improvised Explosive Device (IED) scenario event for the GGEX06 Exercise in San Bernardino County.

The focus for the 2006 Statewide Medical & Health Disaster Exercise will be on patient movement, patient tracking, surge capacity, location and/or allocation scarce resources, coordination with law enforcement, building security and implementation of emergency management plans. This exercise meets the requirements of the Health Resources and Services Administration (HRSA) as well as Centers for Disease Control and Prevention (CDC) grant requirements to conduct bioterrorism exercises and it is consistent with the annual hospital drill/exercise requirements put forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The County (Operational Area) Medical & Health Exercise Contact (*see page 103*) is the point of contact for planning, questions and organization for the exercise. We encourage participants to contact them early in the planning process to assist in the execution of the exercise. The Regional Disaster Medical Health Specialists (RDMHS) *(see page 111)* are available to assist the Operational Area (OA) Medical & Health Exercise Contacts in planning and executing the exercise.

Throughout the exercise plans and documentation are the terms "Directly Affected Areas" and "Indirectly Affected Areas", referring to the Medical/Health play in coordination with the GGEX06 scenario. "Directly Affected Areas" are any areas identified as being directly affected by the events in the GGEX06 scenario (either an earthquake or an IED). The counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Sonoma, Santa Cruz, and San Bernardino represent these areas. "Indirectly Affected Areas" represents all other OAs in the State of California with the intent that they will simulate the provision of medical mutual aid to the "Directly Affected Areas".

Exercise Dates

November 15, 2006	San Francisco Bay Area (Mutual Aid Region II) earthquake and medical mutual aid from all other areas throughout the State.
November 16, 2006	San Bernardino County medical exercise – to include any areas providing medical mutual aid to this area - in response to an IED device that exploded on 11/14/06.

Thank you for the commitment to disaster medical planning and preparedness.
We look forward to hearing about a successful exercise!

In previous years the Statewide Medical & Health Disaster Exercise has been supported by two separate documents, a GUIDEBOOK for exercise participants (hospitals, clinics, ambulance providers, transfusion services, auxiliary communications systems, etc.), and a TOOLKIT for Exercise Coordinators.

To avoid the duplication of information in the two documents, this year's exercise is supported by this one document which combines the information for both the Guidebook (Part 1) and the Toolkit (Part 2).

This Guide has been formatted to accommodate double-sided duplication.

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Part 2 – Toolkit for Exercise Coordinators

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Introduction

For a number of years, the California Emergency Medical Services Authority (EMSA) has taken the lead on a steering committee that develops the Statewide Medical & Health Disaster Exercise. The documentation provided in this Guidebook assists hospitals, clinics, transfusion services, ambulance providers, auxiliary communications systems, Local EMS Agencies, public health, and counties (Operational Areas) in using the scenario, objectives, evaluation tools, etc. in creating a foundation for their individualized exercises. EMSA is committed to developing a statewide exercise that:

- Trains in California's readiness for a major medical disaster that will require coordination with county emergency management as well as other disciplines such as Fire, Law Enforcement, etc.
- Promotes the statewide use and coordination of a Medical/Health Mutual Aid system.
- Moves California forward in efforts of standardization by incorporating the Standardized Emergency Management System (SEMS) and National Incident Command System (NIMS) in planning efforts.
- Builds upon lessons learned from previous exercises.
- Exercises newly developed or revised Surge Capacity plans.

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Disaster planning in the Medical/Health discipline in California has been moving toward a single point of contact (POC) for communications and coordination of resources within the Operational Area (OA). While individual OAs may have different approaches, reporting structures, position descriptions, and names or acronyms for Medical/Health Emergency Operations Centers (EOCs), for the purpose of this document the term OA Medical/Health POC will be used as a generic indicator for consistency and clarity. This term is used throughout the Guidebook to denote either the person or the EOC branch responsible for coordinating Medical/Health disaster response.

Exercise Dates

- Wednesday, November 15th for the San Francisco Bay Area Counties acting as "Directly Affected Areas" in the scenario and for all "Indirectly Affected Areas" in the State providing simulated medical mutual aid to the Bay Area.

Note: **"Directly Affected Areas" are any areas identified as being directly affected by the events in the California Office of Homeland Security's Golden Guardian Exercise 2006 (GGEX06) scenario (either an earthquake or an IED). The counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Sonoma, Santa Cruz, and San Bernardino represent these areas. "Indirectly Affected Areas" represents all other OAs in the State of California with the intent that they will simulate the provision of medical mutual aid to the "Directly Affected Areas".**

- Thursday, November 16th for San Bernardino County utilizing the GGEX06 scenario and for any "Indirectly Affected Areas" providing simulated medical mutual aid to San Bernardino County.

Recognition for Participation

Receipt of Certificate of Participation from EMSA for the November 2006 exercise will require: (Receipt of Certificate does not indicate meeting JCAHO exercise requirements as found on page 83).

1. Participation on the date(s) as outlined above.

2. Facilitation of a stand-alone internal exercise **or** an exercise that is part of a larger community or OA event.

3. Exercise **one** of the following:

    a. Activation and documentation of emergency communications system(s).
    b. Activation of an Emergency Management Plan if utilized by the facility. For hospitals, this should include activation of the Hospital Incident Command System (HICS).
    c. Tabletop exercise to include all considerations and plans for responding to the event were it to happen in the OA.
    d. Functional exercise to test/evaluate individual capabilities or activities.
    e. Full scale exercise to include the handling of patients per scenario details.

4. Submission of an evaluation form (starting on *page 47*) to EMSA by December 8, 2006.

Planning the Exercise and Using This Guidebook

EMSA and the Statewide Medical & Health Disaster Exercise Committee have the following goals in coordinating this year's exercise:

- Provide a Guidebook that facilitates participation in the exercise and eases the burden of developing individual exercise tools.
- Offer as much flexibility as possible to participating entities while maintaining minimum participation standards and guidelines.
- Coordinate with the California Office of Homeland Security's GGEX06 so that healthcare providers and government response agencies can participate in both exercises where applicable.

Any required exercise activity or level of participation is clearly identified in this Guidebook. Much of the information, including the scenario, can be modified to fit specific training/exercise objectives. It is important to note that a facility or entity within a county, regardless of location, can exercise the option to conduct activities of a "Directly Affected Area" or an "Indirectly Affected Area" – no one is locked in to a specific role or type of exercise, but should coordinate their efforts within the OA and the region where possible.

Each entity participating in the exercise should create their Master Sequence of Events List (MSELs) from the scenario provided in this Guidebook, with modifications to suit individual needs. It is recommended that the Shake Map earthquake damage estimate information referenced on *page 87* be utilized to create MSELs appropriate to what would occur in a specific area. The exercise Controller(s) should then use the individualized MSELs to monitor the exercise play and assist with the timelines and events appropriately.

Participants are not required to exercise or meet all objectives listed in this Guidebook. They should be considered based on goals, needs, and priorities of each participating entity.

In coordinating the exercise and using the tools provided in this Guidebook, participants should follow an appropriate chain of command. Hospitals, clinics, ambulance providers, transfusion services, local EMS agencies, health departments, etc. should first contact their OA Exercise Contacts, found on *page 103*, for assistance and guidance. OA representatives should contact their Regional Disaster Medical Health Specialist (RDMHS). RDMHS should contact Anne Bybee at EMSA.

Exercise Timelines

September 15, 2006 Deadline to FAX the Participant Intent to Participate Form (*page 45*) to the OA Medical/Health Exercise Contact (see *page 103*).

September 22, 2006 Deadline to FAX the OA Intent to Participate Form *(page 46)* to the RDMHS (*page 111*)

September 26, 2006 Deadline for RDMHS to FAX OA Intent to Participate Forms to EMSA

November 15, 2006 The exercise scenario has activity from 0512 hours to 1015 hours for the Bay Area "Directly Affected Areas" and from 0645 hours to 1100 hours for "Indirectly Affected Areas" providing mutual aid. Participants may opt to continue exercise for an extended period of time and are encouraged to do so if this meets the exercise events in the community or OA. The regional and state-level EOCs will continue exercise play through the evening hours and then again on November 16th to follow up on Mutual Aid and Resource Allocation issues.

November 16, 2006 The exercise will be conducted from 0830 hours to 1230 hours for San Bernardino County and for areas providing mutual aid to San Bernardino County's Improvised Explosive Device (IED) event.

December 8, 2006 Deadline to complete and submit the appropriate provider-specific Exercise Evaluation (beginning on page 47) to EMSA to receive participation certificates.

Hospital Facility Objectives

NOTE: San Bernardino County hospitals have separate GGEX06 Objectives, and should contact the GGEX06 coordinator or Leigh Overton at loverton@sbcfire.org for this information.

The citing listed after each objective ("EC") refer to applicable section of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Environment of Care Standards.

All Areas:

Objective I:
Implement the facility's Emergency Management Plan using a recognized Incident Management System such as HICS.
(EC 4.10.2 and 4.10.3)

Objective II:
Utilize at least 5 different modes of communication during the exercise to exchange information with OA coordinators and/or other local responders.
(EC 4.10.18)

Objective III:
Demonstrate the ability to use, manage and support the facility's incident response through information exchange with the OA through Reddinet, EMSystem, ETeam, DataTech 911, CAHAN, etc., if utilized in the area.
(EC 4.10.2)

Objective IV:
Demonstrate via at least 3 modalities (video, print, radio, TV, internet based system, 2-way radios, etc.) the ability to coordinate with the Joint Information Center (JIC), if one is active, in providing standardized and uniform risk communication messages, for both internal and external dissemination, following local authority and state guidance. These messages will also need to target major ethnic/language groups pertinent to the community.
(EC 4.10.10)

Objective V:
Activate plans for the use of Alternate Care Sites (ACS) to accommodate a patient influx of either locally evacuated patients or incoming surge from incident casualties.
(EC 4.10.13)

Hospital Facility Objectives, page 2

Objective VI:
Demonstrate the ability to rapidly assess and prioritize patients for rapid discharge (<24 hours). Facilities will be expected to absorb at least 20 percent of their Average Daily Census (or consider using surge numbers from the mid year Health Resources and Services Administration [HRSA] survey) as surge from evacuations and incident casualties over the next 24 hours. This process should include a demonstration of a reliable patient tracking method for internal and external movement of patients.

Objective VII:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Directly Affected Areas:

Objective VIII:
Demonstrate the ability to rapidly assess and prioritize patients for evacuation of the facility, relative to the current Hazard and Vulnerability Assessment. This process should include a demonstration of a reliable patient tracking method for internal and external movement of patients.
(EC 4.10.12)

Objective IX:
Demonstrate the ability to perform a damage and safety assessment to the facility within 2 hours of the seismic event.

Hospital Transfusion Services Objectives

All Areas:

Objective I:
Implement the Transfusion Service portion(s) of the hospital's Emergency Management Plan, including a potential evacuation strategy coordinated in conjunction with the facility's incident command center.

Objective II:
Determine blood product inventory by blood group, assess further estimated need and communicate that information to the hospital Incident Command section and the primary blood supplier within one hour post-event.

Objective III:
Using a previously established protocol, communicate with ED physicians/RNs to determine anticipated estimated time of arrival (ETA) of injured, number of injured, types of injuries, early estimate of types and quantities of blood products that may be required.

Objective IV:
Utilize alternate communication systems to contact primary blood supplier requesting anticipated amount and types of blood product.

Objective V:
Assess management of incoming blood inventory and compatibility testing with qualified transfusion service technologists, and technologist call-back schedules.

Objective VI:
Communicate with pre-determined local "sister" hospitals regarding options for reagents, refrigeration of blood product, inventory transfers, and "runner" support.

Objective VII:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Ambulance Provider Objectives

All Areas:

Objective I:
Apprise the Communications Center of ambulance status including Mutual Aid and California Ambulance Strike Team (AST) availability and communicate that status to local governmental agencies within the OA, utilizing appropriate communication systems.

Objective II:
Assess the ability to manage transportation of mass influx of patients, including the coordination of patient transportation destinations with healthcare facilities. Participate in coordinating patient tracking with the hospitals, the OA (if participating) and with any other identified participants as appropriate.

Objective III:
Implement the provider's emergency preparedness response plan using the Incident Command System (ICS).

Objective IV:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Directly Affected Areas:

Objective V: Participate in assessing the area's resources and working with the OA in determining the need for additional resources from other areas.

Indirectly Affected Areas:

Objective VI:
Assess the area's resources and assure the OA has the ability to continue normal ambulance service after sending ASTs to and receiving a significant surge of patients from the "Directly Affected Areas".

Auxiliary Communications Systems (ACS*) Objectives

All Areas:

Objective I: (Pre-Exercise):
Coordinate with local auxiliary communications radio operators on frequencies, protocols and forms used during an exercise/actual event.

Objective II:
Coordinate ACS* and redundant communications with local Amateur Radio Operators familiar with using established frequencies, protocols and data collection/reporting forms.

Objective III:
Pass two-way communication messages effectively between regional and OA providers.

Objective IV:
Disseminate and use appropriate frequencies for communication of two-way messaging and data transfer.

Objective V:
Assess specific policies & procedures for the authorization and tracking of messages.

Objective VI:
Use FEMA ICS Form 213 to document ACS* message traffic.

Objective VII:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

NOTE: The acronym ACS* (with an asterisk) is used throughout this document to denote Auxiliary Communications System. The acronym ACS (without the asterisk), also commonly accepted, is used to denote Alternate Care Site(s).

Medical Clinic Objectives

All Areas

Objective I:
Using ICS, identify clinic personnel responsible for establishing and maintaining communication with the OA Medical/Health POC, the appropriate OA EOCs, or the parent facility.

Objective II:
Based on incoming information from the OA Medical/Health POC, identify clinic personnel responsible for activating the clinic emergency operations plan and determine appropriate course of action (e.g. remain open for business as usual, serve as Alternate Care Sites [ACS], close clinic, etc.) based on prior planning and recommendations.

Objective III:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Directly Affected Areas

Objective IV:
Assess clinic functionality including: structure, staff availability, supplies and equipment to accommodate an approximate surge of walking wounded and worried well patients from hospital Emergency Department (ED). Communicate the facility's response capability and resources to the OA Medical/Health POC or parent facility and clinic consortia utilizing appropriate communication systems.

Objective V:
Using the ICS structure organization chart determine the appropriate course of action and communicate plan to the clinic section chiefs, department leaders, and staff.

Objective VI:
Coordinate clinic response efforts with local hospitals, city public works, police, fire, ambulance, ACS, clinic consortia and emergency response teams as available (e.g. Medical Reserve Corps [MRC] and Community Emergency Response Team [CERT]).

Indirectly Affected Areas

Objective VII:
Assess response capacity for managing a surge of walking wounded and worried well patients from "Directly Affected Areas" based on clinic's proximity to earthquake epicenter. Assess capacity to assist clinics in affected counties with

resources, e.g. staff volunteers, supplies, equipment, mobile clinics. Assess ability to assist local efforts as an ACS. Communicate approximate surge capacity and resource capabilities to the OA Medical/Health POC or parent facility and clinic consortia utilizing appropriate communication systems.

Objective VIII:
Communicate the appropriate course of action to the clinic section chiefs or department leaders.

Objective IX:
Coordinate clinic response efforts with local hospitals, city public works, police, fire, ambulance, ACS*, and emergency response teams as available (e.g. MRC, CERT)

Local EMS Agency Objectives

All Areas:

Objective I:
Assess the agency's ability to utilize pre-established disaster protocols, evaluating and implementing changes in medical control appropriate to the event.

Objective II:
Assess the agency's ability to provide oversight and system management to hospitals and pre-hospital providers as they respond to the catastrophic events posed.

Objective III:
Determine the agency's ability to assist with the coordination of response resource requests and medical mutual aid.

Objective IV:
Determine the agency's ability to assist in hospitals' assessment of patient bed availability and the communication of this information to the OA EOC.

Objective V:
Participate in OA and regional resource allocation decisions. Assess the results post-exercise and communicate recommendations for system changes/improvements via After Action Reports.

Objective VI:
Participate in patient tracking efforts throughout the disaster response. Assess the results post-exercise and communicate deficiencies via After Action Reports.
Objective VII:
Conduct an After Action briefing and identify gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Public Health Objectives

All Areas:

Objective I:
Assess the role of the local health department during a large-scale natural disaster.

Objective II:
Assess the local health department's ability to collect accurate and pertinent data from the OA Medical/Health POC, or from healthcare providers, including hospitals, clinics, EMS providers and others depending on the structure within the OA.

Objective III:
Assess the local health department's ability to communicate – in coordination with the OA Medical/Health POC - information and health alerts to healthcare providers, including hospitals, clinics, EMS providers and others.

Objective IV:
Working with the JIC if one is established, develop risk communication messages consistent with local emergency managers, hospitals and other officials in a rapid and timely manner for internal and external dissemination.

Objective V:
Assess the AO Medical/Health POC's ability to access and transmit information to region and state medical and health authorities through communication tool, i.e., the Response Information Management System (RIMS) and the California Health Alert Network (CAHAN), where authorized.

Objective VI:
Conduct an After Action briefing and Develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Directly Affected Areas:

Objective VII:
Develop environmental health bulletins to the public regarding water and food safety advice. Coordinate dissemination of these messages through the JIC where applicable.

OA OES Objectives

All Areas:

Objective I:
Assess the OA's ability to collect timely, accurate and appropriate data from participants, including situation reports, status reports, and incident specific RIMS forms.

Objective II:
Implement Emergency Operations Center (EOC) procedures and mechanisms for managing a large scale medical event, including the procurement, management and allocation of scarce resources within the OA.

Objective III:
Demonstrate the ability to access, enter, and transmit data via RIMS to regional and state authorities.

Objective IV:
Activate ACS* and pass two-way messages to OA participants, regional providers and the RDMHS.

Objective V:
Assess the OA Medical/Health POC's ability to coordinate patient tracking with the hospitals and with any other identified participants as appropriate.

Objective VI:
Conduct an After Action briefing and develop an After Action Report identifying gaps and weaknesses in emergency operations plan. Develop and implement a corrective action plan.

Directly Affected Areas:

Objective VII:
Develop risk communication messages consistent with appropriate public health doctrine in a rapid and timely manner for internal and external dissemination. Coordinate through the JIC if one is established.

Objective VIII:
Together with the Local EMS Agency, assess the OA's ability to receive and manage incoming ASTs.

OA OES Objectives, page 2

Objective IX:
Assist the OA Medical/Health POC in locating and establishing Field Treatment Sites (FTS) or ACS to manage the overwhelming number of casualties or patients being evacuated from damaged hospitals.

Objective X:
Assess back up resource response systems or techniques to mitigate potential problems associated with at least one system critical to the operation of a health care facility, e.g. loss of water, power, computers, sewer, natural gas, etc.

Indirectly Affected Areas:

Objective XI:
Together with the Local EMS Agency, assess the OA's ability to determine local resources for the reception and transportation of incoming casualties from "Directly Affected Areas" and the placement of those patients at local hospitals or other appropriate healthcare facilities.

Objective XII:
Together with the Local EMS Agency, assess the OA's ability to track incoming patients from out of the area at all levels including, hospitals, clinics and other care sites that will receive patients.

Objective XIII:
Together with the Local EMS Agency, assess the OA's ability to organize and dispatch ASTs to affected counties as directed.

Objective XIV:
Together with the Local EMS Agency, assess the OA's ability to continue to provide hospital service after receiving a significant surge of patients from the "Directly Affected Areas".

Objective XV:
Together with the Local EMS Agency, assess the OA's ability to continue to provide ambulance service after sending ASTs to the "Directly Affected Areas".

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Background for Exercise Scenario

** See note at end of next page regarding San Bernardino County*

At 0512 hours a foreshock occurs on the northern segment of the San Andreas Earthquake Fault sufficiently strong to be felt throughout the San Francisco Bay Area. About 25 seconds later the main shock occurs with a Moment Magnitude of 7.9 (Mw 7.9)[1]. The violent shaking lasts 60 seconds. The epicenter is located just north of the city of San Francisco on the San Andreas Fault. The shaking intensity ranges from a Modified Mercalli Intensity (MMI)[2] scale of VII to IX parallel and up to 50 miles from the rupture. *MMI VII is characterized as: "Damage negligible in buildings of good design and construction; slight to moderate in well-built ordinary structures; considerable damage in poorly built or badly designed structures; some chimneys broken." MMI IX is characterized as: "Damage considerable in specially designed structures; well-designed frame structures thrown out of plumb. Damage is great in substantial buildings, with partial collapse. Buildings have shifted off foundations."*[3]

The rupture of the San Andreas Fault extends from north of San Juan Bautista to the triple junction at Cape Mendocino for a distance of 277 miles. The shaking is felt from the Oregon border to south of Los Angeles and into central Nevada

Un-reinforced masonry buildings and buildings with a "soft story" have totally to partially collapsed throughout the area adjacent to the rupture. Because of the early hour, many are trapped under the debris. The damage to buildings is worse in areas of sediment fill versus areas of bed rock. Ruptured gas mains and lines have started many fires in the streets and in buildings. Water mains have ruptured throughout the area. Telephone service including cell phones is very spotty to non-existent not only because of equipment and transmission line damage but also because of system overloads.

Many hospitals rated as Structural Performance Category 1 (SPC-1) (a high probability of collapse) have damage ranging from partial to near total collapse of the acute care areas. At some hospitals, especially those that are Non-Structural Performance Category 2 (NPC-2), the broken sprinkler system piping has caused the facility to evacuate and move its operations out to the adjacent parking lot. Electric transformers have been shifted by the shaking and shorted out certain segments of the hospital. Many clinic buildings, special nursing facilities, board and care facilities and

[1] Magnitude is a measure of the amplitude of the maximum ground motion measured on a seismograph (See USGS at: http://earthquake.usgs.gov/learning/glossary.php?termID=118)
[2] Modified Mercalli Intensity is a subjective description of the shaking and damage (See: http://earthquake.usgs.gov/learning/glossary.php?termID=99)
[3] http://earthquake.usgs.gov/learning/topics/mercalli.php

long term care facilities while intact have no electricity and do not have emergency electrical generator capabilities. NPC-2 buildings with ceiling tiles require the tiles to be cleared from the floors prior to moving patients.

All bridges are closed for inspection and some have obvious gross damage to the bridge or its approaches. Landslides and collapsed overpasses have closed many roads. Individuals are trapped in their vehicles under the collapsed overpasses.

There will be hundreds of deaths and many thousands of victims with severe to minor crush injuries. There will also be an increase in the number of early term birth deliveries, and a significant increase in patients with respiratory problems ranging from bronchitis to asthma. In areas of power outages, patients on home oxygen concentrators will soon deplete their small bottles of emergency oxygen. Many individuals with special needs will need assistance.

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** Hospitals in San Bernardino County – and any facilities wishing to build an exercise where they provide medical mutual aid to San Bernardino County - will have a separate scenario supporting the GGEX06 IED event that occurs on 11/14/06, with the primary hospital portion of the exercise being conducted on 11/16/06. For information on this event, contact Leigh Overton at loverton@sbcfire.org and communicate your intentions to the OA Medical & Health Exercise Contact (see page 103).*

Participants may adapt the scenario to create MSELs or injects that best meet their training needs. Participants have the option to design and conduct the exercise to their own preferences (for example, a hospital in a county not identified as one of the "Directly Affected" GGEX06 areas could design an exercise as if they had the earthquake hit their city; or vice versa, a hospital in a "Directly Affected" GGEX06 county could chose to design an exercise where they had no damage and offered to accept patients from evacuating facilities). Ideally this should be coordinated through the OA Medical/Health Exercise Contact/Coordinator.

Exercise Scenario
"Directly Affected Areas"

Bold font indicates sentinel or critical events.

0512 **Earthquake occurs.**

0514 **Some hospitals have no electrical power and their emergency generators are not operational.**

0517 California Integrated Seismic Network (CISN) posts location, magnitude
UC Berkeley confirms magnitude, location to State Warning Center.

West Coast and Alaska Tsunami Warning Center (WCATWC) issues a Tsunami Warning Bulletin.

0520 **Hospitals are unable to contact their Medical Dispatch Center by phone because of system overload, therefore attempt to reach the OA Medical/Health POC by alternate means of communication.**

Hospitals are beginning to activate HICS.

Considerations and Decisions:

- *What are the initial hospital status reporting data elements required to the OA? How are they reported?*
- *Does the hospital use HICS - and what are the triggers for activation?*

Field units are beginning to report that there are large city areas with building collapses, fires, injuries, deaths, trapped victims, obstructed streets.

Medical dispatch centers are being overloaded with requests from hospitals for assistance for injuries, evacuations, security, etc. 911 centers are flooded with calls for help from the community.

0528 **Hospital staff is attempting to respond to their own patient/staff injuries, attempting to free those trapped by debris and surveying for damage. Some supervisory personnel have been seriously injured or killed.**

Considerations and Decisions:

- *If the facility stores pharmaceutical caches or other heat-sensitive items, what is the plan for back-up or manual temperature control of the room if the power is out?*

EMS/Medical dispatch centers begin polling EMS units and hospitals for status.

Fire and Law dispatch centers begin polling status of units and stations.

Law enforcement and fire units begin surveying their areas for damage, injuries, street conditions, fires.

Considerations and Decisions*:*

- *How does the organization deal with staff concerns and the possibility of their family members being casualties of the event?*
- *How are on-site determinations of death made and by whom?*
- *Where have employees been oriented to report should bridge-outages and other traffic problems affect their ability to return to work?*
- *What is the resource allocation process for scarce resources when confronted by this potential mass casualty incident?*
- *What is the process to procure additional resources (e.g. staffing, blood, trauma supplies, body bags, inpatient beds, emergency department and/or operating room beds, morgue refrigeration units)?*

0530 **Hospitals with major collapse are attempting to evacuate their entire facilities and continue to request OA assistance. Other hospitals are evacuating major portions or areas of their facility. Ambulances and ASTs are dispatched for the evacuations.**

Most hospitals with SPC-2 will remain standing but will not remain operational. Hospitals classified as SPC-3, 4 or 5 will probably remain functional and may treat their own patients and staff injured during the shaking.

Hospitals with NPC-2 damage are assessing sprinkler systems, oxygen delivery systems, etc. to determine ability to continue operations.

Hospital Transfusion Services are contacting their Blood Centers for product.

Hospitals in the process of evacuation attempt to contact community Blood Centers for advice on how best to preserve their blood products.

Hospitals are prioritizing patients for internal movement and/or external evacuations.

Fire field units are requesting full fire assignments for each of the many fires and for fire units to assist in the rescue of those trapped in debris of collapsed buildings and overpasses.

State Office of Emergency Services (OES) is reporting the approximate epicenter of the earthquake and the estimated magnitude. (See background at beginning of scenario.)

Personnel are attempting to return to staff the OA, regional and state-level EOCs.

Some blood centers are operating on emergency power. One or two have sustained significant damage.

Considerations and Decisions:

- *How does the facility conduct initial structural assessments? Who from outside the facility is involved, and how is contact with them made?*
- *If immediate evacuation of the facility is required, what are the initial contingency plans?*
- *What redundant communication systems are in place for such an event?*
- *Estimate how long would it take to evacuate the facility?*

0545 **Injured victims from the community have begun to flood in to the closest hospitals.**

Requests have been made to key radio and TV stations to announce that off-duty personnel (fire, law, medical, public works, etc.) should return to their duty stations.

Medical dispatch has been unable to contact many hospitals.

Considerations and Decisions:

- *What contingency plans are in place if these off-duty personnel cannot get to their normal place of work? Are there options available?*
- *Who/How are assessments made of hospitals with which contact cannot be established?*

There are many more requests to dispatch ambulances/paramedic units than are available.

0600 **Hospitals have requested assistance from their own corporate headquarters and their OAs simultaneously. Many requests cannot be met.**

HICS has been established at most hospitals.

Hospitals are attempting to set-up their surge tents.

California Highway Patrol (CHP) and news helicopters are reporting sites of road closures, levee leaks, and dams that show damage.

ACS* staff begins to appear at OA, regional and state-level EOCs, blood centers and hospitals.

State Department of Water Resources (DWR) staff are arriving at their Flood Operations Center and activating emergency operations.

Considerations and Decisions:

- *How is status of corporate or private resource sharing reported to the OA?*

0607 Tsunami warning is cancelled with the conclusion that no damaging waves have been generated.

0615 **Many hospitals are functioning, but have extensive non-structural damage and some structural damage.**

More fires have started in the community. Some fire stations have been unable to raise their equipment bay doors to move their equipment out and thus are out of service.

There are many dazed community residents wandering the streets.

Requests have gone out to the DWR to attempt to shut down areas where the water mains have broken and are sending large quantities of water into the streets.

Requests have gone out to the local power provider to de-activate fallen power lines.

DWR field personnel are contacted and dispatched to investigate suspected levee leaks and damaged dams.

0630 **Many hospitals are now overwhelmed by their own circumstances and an influx of patients. Some ambulances have been able to bring critically injured victims to the hospital.**

Hospital supplies are now running extremely low and they have requested assistance through the OA Medical/Health POC then who requests pharmaceuticals, surgical supplies, and staff from the RDMHS.

OA, regional and state-level EOCs are now sufficiently staffed to be operational.

Region II RDMHC/S is polling unaffected counties for assistance in staffing, equipment and supplies.

Law and Fire command have requested activation of their mutual-aid system for assistance from neighboring counties.

The State Operations Center (SOC) has requested that the Governor declare a State of Emergency.

0645 **Spontaneous volunteers are appearing at local hospitals and blood centers.**

Law enforcement has established perimeter roadblocks and staff returning to their hospitals are having difficulty passing through these blockades. Hospitals have requested assistance through the OA Medical/Health POC.

The OA Medical/Health POCs have all sent requests for staff supplements (for both medical facilities and EOCs) to the RDMHS.

Region II RDMHC/S has sent a request to the Regional Emergency Operations Center (REOC) for supplemental medical personnel for FTS, hospital staff augmentation, etc.

County Public Health DOCs have all been activated.

The American Red Cross (ARC) has activated their EOCs and has notified the Pacific Service Area that they are now in service.

Considerations and Decisions:

- *Clinics will soon be opening where possible. Is the emergency plan in place for obtaining additional staff at the hospital in anticipation of increased patient census?*
- *Is there a credentialing procedure for convergent volunteers?*
- *Is there a badging/identification system to allow Medical/Health personnel through roadblocks?*

0700 **Hospital patients are expiring due to lack of critical support, and the facilities are accumulating more deceased than their morgues can handle. They have requested body bags and assistance from the Coroner through the OA Medical/Health POC.**

There is a need at all hospitals to initiate austere medical care protocols.

Considerations and Decisions:

- *Does the facility have austere medical care protocols? If so, who else within the community is involved?*

The Governor has declared a State of Emergency and also sent a request to the President for a Federal Declaration of Emergency.

There are multiple requests for Urban Search & Rescue (US&R) Teams, for National Disaster Medical Systems' (NDMS) Patient Bed Counts, and for patient transport assistance.

There are many deceased people being found in the community and the Coroner's Office is receiving many requests to take care of these remains.

The Coroner's Officer through the OA EOC has made a request to the REOC for assistance.

The ARC EOC has begun to establish shelters but is short of Registered Nurses (RN) to staff these shelters and they have requested Public Health Nurses through the REOC.

Considerations and Decisions:

- *Who is the hospital's contact to the OA Medical/Health Mutual Aid System? How is initial contact with this person made and how is contact maintained? What information will be needed when contact is made?*

0715 **Some hospitals are overwhelmed with incoming patients, and are requesting that the OA Medical/Health POC consider the establishment of an ACS at a suitable nearby location.**

Considerations and Decisions:

- *How will off-site or on-site, soft-sided structure patient care services be established and communicated to the community?*

There is an electrical outage in the city. Many patients who require electricity at home to run their medical equipment (oxygen concentrators, pumps, ventilators, etc.) are being brought in an unorganized fashion via any means of transportation to the nearest hospital for care.

Those in the community whose homes have minor damage want to know if the tap water is safe to drink without boiling.

Closer examination by DWR of the damaged dam suggests it has the potential to collapse in a major aftershock.

There is already flooding where levees have been breeched.

0730 **M7.0 Aftershock Occurs**

The shaking has caused a freestanding transformer at a hospital to shift and short out occurs leaving a major acute care area without electricity.

Staff and patients at a hospital are injured trying to flee the facility during this aftershock.

Numerous hospitals are contacting community Blood Centers for additional units of blood and blood products. Blood needs assessment is started and will be reported to Blood Centers via the Hospital Transfusion Services.

The Governor has activated the California National Guard (CNG) and now the SOC has been tasked to work with CNG to determine where the units should be deployed.

More damaged structures in the community have collapsed.

0745 **Hospitals that have moved their emergency care into the parking lot are rapidly depleting the contents of their portable oxygen tanks and are requesting additional supplies through the OA Medical/Health POC.**

Blood Centers are being flooded with requests for blood and blood products.

Clinic employees, when arriving to open for the day, are being confronted by large numbers of worried-well, individuals with minor crush injuries, individuals with medication needs and a few patients with major medical problems that need to be transferred to a definitive care facility.

Some clinics face a secondary problem of being without electricity and having no emergency generator capability. They have called 911 requesting the fire department bring them portable generators.

Clinics are attempting to activate their Emergency Management Plan utilizing ICS.

A few ARC shelters are being established. Public announcements are being developed at the JIC.

CERTs are now active and requesting that the injured they have given first-aid to be transported to a hospital.

Local officials, after consulting with DWR staff or the dam's operator, now feel that the population below the threatened dam should be immediately evacuated.

MRC unit leaders are calling their OA EOC informing the staff that their members are ready to respond and want to know their mission assignments.

At an industrial complex, an irritating vapor is being released from a damaged large tank structure.

Communities of non-English speaking individuals need help from their own Community Based Organizations (CBO).

0800 **Hospitals need to have overload of patients transferred to facilities out of the affected area.**

Hospitals have now realized they are not following the staffing and bed ratio regulations and have requested through their Health Department the relaxing of these regulations to meet the needs of the emergency.

Many hospitals have depleted their blood supply, especially Type O and are requesting additional supplies through their Blood Centers. Blood Centers are communicating with California Blood Bank Society (CBBS) Area Emergency Operations Centers (AEOCs) for blood supplies from Indirectly Affected Areas. The American Association of Blood Banks (AABB) has been alerted from the Sacramento AEOC regarding supplies outside the state. Sacramento AEOC is updating the region on blood supply availability.

Most of the hospital needs are now being relayed to the OA EOC by ACS* staff at the hospitals.

ACS* staff is also providing the communications between hospitals, between hospitals and blood centers, and between blood centers. The CBBS RadioNet is communicating between blood centers through the AEOC.

Considerations and Decisions:

- *What is the process of establishing this transfer of patients?*
- *Does the facility have enough ACS* staff to deliver the radio information as stated above?*
- *What patient tracking system is to be utilized?*
- *Whose responsibility is it to develop and coordinate this patient transfer?*
- *Do the hospitals need permission to provide only austere medical care?*

Fires continue to burn in the community.

0830 **Hospitals are requesting staff relief for the next 12-hour shift (1700 hrs) through the OA Medical/Health POC. Because of damage to their homes or family needs, some of the hospitals own staff has been unable or unwilling to return to work (all levels – physicians, nurses, clerical, environmental services, engineering, etc).**

Clinic(s) are contacting the OA Medical/Health POC or their parent company and requesting medical assistance, supplies and transportation for the more seriously injured and ill patients. Clinic consortia representatives are being contacted to assist with the coordination of medical care and requests for supplies/equipment.

Considerations and Decisions:

- *Survivors rescued from areas flooded by damaged levees have brought their pets with them. Will the ARC shelters allow these individuals to stay at the shelter with their pets?*

0900 **Some returning hospital staff members have brought family members and/or their pets with them.**

There is sufficient food and drink to supply hospital staff and patients, but not for first responders or family members.

Considerations and Decisions:

- *How will the needs of first responders be handled?*
- *How will the needs of family members who have accompanied the patients to the hospital be met?*

Two competing pharmacies are both damaged but the proprietors are willing to join forces and operate as a single entity during this emergency period.

Law enforcement agencies are investigating rumors of local looting.

Local business owners are demanding that they be allowed back into their business establishments to see what is left, but law enforcement is under orders not to allow anyone back into badly damaged buildings.

Considerations and Decisions:

- *Is this legal to have competing pharmacies join forces? Who should they request permission from to begin operations?*

0930 **Many of the injured brought to hospitals still have not been seen by the medical staff, and their family members are becoming agitated and are voicing loud demands for immediate care. Hospital security officers do not feel they can control the growing protests.**

The ARC does not have sufficient trained volunteers to open the number of shelters required and have requested through the OA that local officials provide staff to assist in opening additional shelters.

The Salvation Army has also activated their Emergency Management Plan and is assisting with the care and housing of the many thousands of displaced people.

Considerations and Decisions:

- *What options does the hospital have to obtain additional security assistance?*
- *What agreements are in place in the community to assist with access to resources?*
- *Is there a plan in place to handle pets arriving with staff, family members or victims?*

1015 **M6.0 Aftershock Occurs**

Weakened portions of some hospitals have collapsed. Some staff members are trapped in the debris.

NOTE: While this ends the state-scripted play for the "Directly Affected Area", participants are encouraged to continue the exercise into the afternoon or evening hours if this fits into the plans for the OA exercise. The regional and state EOCs and the RDMHC/S staff will continue exercise involvement through the afternoon hours of 11/16 and will be available for communications and coordination.

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Exercise Scenario
"Indirectly Affected Areas"

Note: Participants may adapt the scenario to best meet their training/exercise needs.

0645 **OA Medical/Health POC is contacting hospitals asking for information on availability of beds and staff to provide mutual aid to the "Directly Affected Areas".**

0700 **Administration considers shift change options.**

Considerations and Decisions:

- *Does the facility have standard policy and procedure for staff hold-over in emergency or critical situations?*
- *How are decisions made regarding keeping staff over the end of their shift?*

0745 **Hospitals conduct briefings to administration**

Considerations and Decisions:

- *Who is the hospital's contact to the OA Medical/Health Mutual Aid System? How is initial contact made with this person and how is contact maintained? What information will be needed when contact is made?*

0800 **All polling has been completed for hospitals and ambulance/paramedic units in each OA area, and status information has been sent to Region II RDMHC/S by the OA Medical/Health POC.**

Each OA Medical/Health POC is asking their hospitals for the number of (stable) trauma, medical and psych patients they will be able to receive in the next 6 hours. They are to report back within the next hour.

Ambulance/paramedic providers are being asked how many units they can release to send to the "Directly Affected Areas". They are told to report back to the OA Medical/Health POC within an hour.

Clinics located in close proximity to "Directly Affected Areas" are experiencing surge of walk-in individuals with minor injuries requesting same day appointments. Some clinics have people lingering in clinic waiting areas seeking information, reassurance, or counseling.

Clinics are attempting to activate their Emergency Management Plan utilizing ICS.

Blood banks outside the quake-impacted area have been contacted by their CBBS AEOC with requests for blood to be sent to the CBBS blood banks inside the impact area. Transportation is being arranged. The CBBS has made a request to the AABB for blood supplies from outside California.

Considerations and Decisions:

- *Does the hospital use HICS and what are the triggers for activation?*
- *Is the community participating in state-activated ASTs?*

0900 **Some hospitals have already received patients from the adjacent "Directly Affected Areas" brought by privately owned vehicles and are in the process of establishing HICS to manage mutual aid to the hospitals in the "Directly Affected Areas".**

Hospitals are polling their staff for volunteers willing to travel and work in the "Directly Affected Areas". This list is being cross-referenced with any advanced registry of volunteer healthcare providers for disaster response.

OAs have activated a limited portion of their EOC to manage the requests from Region II for staff and supplies to be sent to the "Directly Affected Areas, to both hospitals and FTS.

Private and public pre-hospital providers are forming ASTs to respond to the "Directly Affected Areas".

Considerations and Decisions:

- *What mechanism is in place to track patients transferred from one facility to another?*
- *Who will families contact for assistance in finding their loved ones? How is this process managed globally in the community?*

0930 **The first helicopters with patients begin to arrive at a community receiving site and the patients are then transferred to local hospitals by ground ambulances. The conditions of some patients have degraded during the transport.**

Hospitals, in anticipation of increased transfusion needs, have contacted the local blood centers for additional units of blood and platelets.

Spontaneous volunteers (physicians, RNs, EMTs and individuals with no medical training) are appearing at hospitals stating they would like to go to the "Directly Affected Areas" and provide service.

Considerations and Decisions:

- *What options does the hospital have to obtain quick additional security assistance?*
- *What agreements are in place in the community to assist with quick access to resources?*

- *How will the community handle the additional ambulance load (transferring patients coming in from affected area) and still keep up with day-to-day business?*
- *What is the credentialing process for spontaneous medical volunteers?*

1000 **Hospitals in the "Indirectly Affected Areas" who have been receiving patients are now running short of supplies, especially if they sent supplies earlier to the "Directly Affected Areas". Their normal vendors cannot fulfill their requests.**

There is a rumor that a patient recently returned from Indonesia has avian influenza but no one knows if this is true and to what "Indirectly Affected Area" hospital he may have been transferred.

Considerations and Decisions:

- *What systems are in place for tracking communicable diseases?*
- *Who does the facility contact when communicable diseases are suspected?*
- *Are the policies and procedures for communicable diseases current and complete?*

1030 **Vacationing physicians and nurses in "Indirectly Affected Areas" have heard over the radio that patients are being transferred to local hospitals and now appear at the hospital to volunteer their services.**

Considerations and Decisions:

- *Can an emergency registration system be used to verify the qualifications of volunteers? Will the hospital allow them to work if they have been pre-registered and credentialed by the State?*

1050 **A military airlift of patients from the "Directly Affected Area" is now operational and 100 patients have arrived at an airport in the OA. The patients are off-loaded and transferred by ground transportation to area hospitals.**

Considerations and Decisions:

- *Who controls where the patients are sent?*
- *Is there a system in place to continue the tracking of these patients at the hospitals?*
- *Since families (except parents of small children or infants) are not allowed to travel with the patients, how will these family members be notified of the final destination of the patient?*

1100 **Some "Indirectly Affected" hospitals have notified their OA Medical/Health POC that they are unable to accept any more patients.**

Hospitals are requesting that the OA establish or locate sites for ACS* to handle the hospital overload of patients.

NOTE: While this ends the state-scripted play for the "Indirectly Affected Area", participants are encouraged to continue the exercise into the afternoon or evening hours if this fits into the plans for the OA exercise. The regional and state emergency operations centers and the RDMHC/S staff will continue exercise involvement through the afternoon hours of 11/16 and will be available for communications and coordination.

****

Statistics Worksheet for the OA:

The following information data sets for hospital and EMS transportation management are under development by EMSA for potential use in future disaster management and may be helpful to the OA in capturing and reporting data in the exercise conduct.

EMS Hospital by OA

OES Mutual Aid Region: _____

County: _____

Facility Name: _____

Hospital's Ability to Accept ED Patients

Immediate _____

Delayed _____

Minor _____

Hospital's Ability to Accept Inpatients

ICU _____

Pediatric _____

OB _____

Med/Surge _____

Psych _____

Isolation _____

Hospital Status

Green (Fully Functional) _____

Yellow (Partially Functional) _____

Red (Non-Functional) _____

Statistics Worksheet for the OA, continued

EMS Hospital by OA, continued

Maintenance Service(s) Needed: _____

Self Sustained

* 0 – 12 hours _____

* > 12 hours _____

Critical Needs: _____

Last Update: _____

****

EMS Transport by OA

OES Mutual Aid Region: _____

County: _____

Provider Name: _____

Ambulance Units Available:

	Total	Capacity
ALS 3 Hour	_____	_____
ALS 24 Hour	_____	_____
BLS 3 Hour	_____	_____
BLS 24 Hour	_____	_____

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Sample Pre-Exercise Public Information Office (PIO) Media Advisory

Date: November XX, 2006

Contact: Jane Doe
(XXX) XXX-XXXX

What: California is conducting its eighth annual Statewide Medical & Health Disaster Exercise. Many hospitals, clinics, ambulance providers, EMS agencies, public health and local governments across the state will voluntarily participate in the exercise. The scenario for the exercise, a major Bay Area earthquake and an improvised explosive device (IED) in Southern California, exercises the response of healthcare providers and governmental agencies to manage the influx of a large number of casualties and the management of resources needed to care for the patients. Last year over 300 healthcare facilities and ancillary healthcare providers, and many counties in California participated in the exercise.

When: Wednesday, November 15, 2006, starting at 0512 **or**
Thursday, November 16, 2006 starting at 0830

Where: In hospitals and other healthcare provider organizations, public health, ambulance services and local government agencies throughout the State.

Who: Exercise planners and supporters of this exercise include the California Emergency Medical Services Authority; the California Department of Health Services; State, Regional and Local Office of Emergency Services; California Hospital Association; Regional Hospital Associations; Auxiliary Communications Systems (ACS) volunteers; local EMS Agencies, California Blood Bank; and hospitals and health care systems.

Background: Participating in this exercise will help California communities be better prepared to respond to an actual natural disaster or terrorist event, should one occur. Hospital participation in this exercise may also qualify as a formal disaster drill with an influx of patients as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that accredits hospitals, and meets the Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) grant requirements for exercises.

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Participant Intent to Participate

- Please complete this form for each individual healthcare facility, ambulance provider or entity participating in the exercise to indicate intent to participate in the exercise.
- FAX THIS FORM TO THE OA MEDICAL/HEALTH EXERCISE CONTACT *(LISTED ON PAGE 103)* **BY FRIDAY, SEPTEMBER 15TH.**

Type of Provider:

Hospital Ancillary Healthcare Facility Clinic Hospital Transfusion Service

Ambulance Provider Auxiliary Communications Service Local EMS Agency

Public Health Operational Area

Name of Facility or Provider: _____

Address: _____

City: _____ **Zip:** _____

County: _____

Exercise Coordinator or Contact: _____

Telephone #: _____ **Fax #:** _____

E-mail: _____

Please check appropriate box for the facility/agency participation in the Statewide Exercise (facility can chose any option regardless of whether it falls into the GGEX06 Directly Affected Areas or not):

- o Will participate Wednesday, November 15, 2006 as a Bay Area "Directly Affected Area" facility or entity
- o Will participate Wednesday, November 15, 2006 as an "Indirectly Affected Area" providing medical mutual aid to the Bay Area
- o Will participate Thursday, November 16, 2006 as a San Bernardino County facility or entity utilizing the GGEX06 scenario
- o Will participate Thursday, November 16, 2006, as an entity providing medical mutual aid to San Bernardino County

OA Intent to Participate

The Medical/Health Exercise Contact will complete this form and fax to the RDMHS (listed on *page 111*) **by Friday, September 22, 2006**

RDMHS Staff will forward this information for each OA in the region to Anne Bybee at EMSA **by Tuesday, September 26, 2006**, FAX # 916-323-4898.

OA: _____

OA Medical/Health
Exercise Contact Name: _____

Address: _____

City: _____ Zip: _____

Telephone #: _____ Fax #: _____

E-mail: _____

OA Agencies	Intent to Participate in the OA Exercise (Check One Column)		
	Yes, Will Participate		No, Will Not Participate
Local Emergency Medical Services Agency LEMSA)			
Local Health Officer/Public Health			
Medical Health OA Coordinator (MHOAC)			
Local Office of Emergency Services (OES)			
Auxiliary Communications Systems (ACS*)			
Other- Specify:			
OA Participants	**Total # in County**	**Yes, will Participate (# Participating)**	**No, Will Not Participate**
Hospitals, Acute Care			
Other Healthcare facilities (SNF)			
Psychiatric Hospitals, facilities			
Clinics			
Ambulance Providers and Agencies:			
Transfusion Services and Agencies:			
Auxiliary Communications Services:			
Public Health Entities:			
Other- Specify:			
Other – Specify:			

Hospital Facility Evaluation Form

NOTE: Participants in the GGEX06 may have separate evaluation forms and tools for that exercise, and should contact their GGEX06 coordinator for further information.

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Hospital/Healthcare Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Circle the <u>single best answer</u> that describes the facility.

A. Acute care hospital with a basic or comprehensive emergency department
B. Acute care hospital with a stand-by emergency department
C. Acute care hospital with no emergency department
D. Specialty care hospital (i.e., trauma, pediatric, etc.)
E. Other

Circle the <u>single best answer</u> that describes the number of beds at the facility.

A. 0 – 99 beds
B. 100 – 299 beds
C. 300 – 499 beds
D. > 500 beds

Hospital Facility Exercise Evaluation Form, page 2 of 3

Please indicate the level of participation of the facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

All Areas:

Objective I: To what extent did the facility succeed in implementing its Emergency Management Plan using HICS?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent did the facility succeed in communicating with OA coordinators and/or other local responders through at least 5 different modalities?

0% 20% 40% 60% 80% 100% N/A

What modalities were tested? _____

Objective III: To what extent did the facility succeed in managing and supporting the incident through information exchange with the OA and through the use of an integrated multi-agency coordinated system (e.g. Reddinet, EMSystem, ETeam, etc.)

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent did the facility succeed in providing standardized and uniform risk communication messages following local authority and state guidance?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was the facility able to rapidly activate plans for the use of ACS to accommodate a patient influx of either locally evacuated patients or incoming surge from incident casualties?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was the facility able to rapidly assess and prioritize patients for rapid discharge, and to what extent was the facility able to absorb at least 20 percent of the Average Daily Census as surge from evacuations and incident casualties?

0% 20% 40% 60% 80% 100% N/A

Hospital Facility Exercise Evaluation Form, page 3 of 3

Objective VII: To what extent was the facility able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses, and develop a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

"Directly Affected Areas"

Objective VIII: To what extent was the facility able to rapidly assess and prioritize patients for evacuation of the facility, demonstrating a reliable patient tracking method for internal and external movement of the patients?

0% 20% 40% 60% 80% 100% N/A

Objective IX: To what extent was the facility able to perform a damage and safety assessment within 2 hours of the seismic event?

0% 20% 40% 60% 80% 100% N/A

All Areas:

How would you evaluate the facility's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

_____

_____

_____

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Hospital Transfusion Services Evaluation Form

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Transfusion Service Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the <u>single best answer</u> that describes the facility.

A. Acute Care Hospital with Transfusion Service and Blood Donor Facility.
B. Acute Care Hospital with Transfusion Service.
C. Hospital with general laboratory.

Please indicate the level of participation of the facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

Hospital Transfusion Service Evaluation Form, page 2 of 3

All Areas:

Objective I: To what extent did the transfusion service succeed in implementing the Transfusion Service portion(s) of the hospital's Emergency Management Plan, including an evacuation strategy in conjunction with the facility's incident command center?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent did the transfusion service succeed in determining blood product inventory by blood Group and assess the further estimated need, communicating this information to the Hospital ICS and the primary blood supplier within one hour of the event?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did the transfusion service succeed in communicating with the ED physicians/RNs to determine anticipated ETA of injured, number of injured, types of injuries, early estimate of types and quantities of blood products that may be required?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was the transfusion service able to utilize alternate communications systems to contact primary blood supplier requesting anticipated amount and types of blood product?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent did the transfusion service succeed in managing the incoming blood inventory and compatibility testing with qualified transfusion service technologists?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was communication with "sister" hospitals established to identify options for reagents, refrigeration of blood product, inventory transfers, and "runner" support?

0% 20% 40% 60% 80% 100% N/A

Objective VII: To what extent was the facility able to conduct an After Action Briefing, develop an After Action Report identifying gaps/weaknesses, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate the facility's response to the event and initiation of the Emergency Management Plan as it relates to the transfusion service?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified

Hospital Transfusion Service Evaluation Form, page 3 of 3

C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

_____

_____

_____

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Ambulance Provider Evaluation Form

Please print and submit one evaluation form only for each provider to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Ambulance Provider Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the single best answer that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the single best answer that describes the service.

A. Basic Life Support
B. Advanced Life Support
C. Both A and B
D. Nurse Critical Care Transport
E. Respiratory Therapist
F. Bariatric Transport
G. Other (specify) _____

Circle the single best answer that describes the service.

A. Private business
B. Fire service affiliate
C. Special district or local government (other than fire service)
D. Hospital affiliate
E. Other (specify) _____

Ambulance Provider Evaluation Form, page 2 of 3

Check the level of participation of the service during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

All Areas:

Objective I: To what extent was the service able to apprise the Communication Center of ambulance status including Mutual Aid and AST availability and communicate that status to local government agencies within the OA?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was the service able to manage transportation of mass influx of patients and participate in coordinating Patient tracking with the hospitals and the OA?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent did the ambulance service succeed in implementing the emergency preparedness response plan using ICS?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was the service able to conduct an After Action Briefing, develop an After Action Report identifying gaps/weaknesses, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

"Directly Affected Areas":

Objective V: To what extent was the service able participate in assessing the area's resources and work with the OA in determining the need for additional resources from other areas?

0% 20% 40% 60% 80% 100% N/A

"Indirectly Affected Areas":

Objective VI: To what extent was the service able to assess the area's resources and assure the OA has ability to continue normal ambulance service after sending ASTs to and receiving a significant surge of patients from the "Directly Affected Areas"?

0% 20% 40% 60% 80% 100% N/A

Ambulance Provider Evaluation Form, page 3 of 3

All Areas:

How would you evaluate the service's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Auxiliary Communications Systems (ACS*) Evaluation Form

Please print and submit <u>one evaluation form only</u> for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Amateur Radio Organization Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Please circle the <u>single best answer</u> that describes the service.

A. Amateur Radio Volunteer
B. CARES
C. RACES
D. Other (specify) _____

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't know

<u>Objective I:</u> (Pre-Exercise) To what extent were radio operators familiar with auxiliary communication protocols, frequencies, available backup frequencies and relevant forms?

0% 20% 40% 60% 80% 100% N/A

ACS* Evaluation Form, page 2 of 3

Objective II: To what extent were radio operators able to setup operational alternative/redundant systems, access appropriate frequencies and complete relevant forms?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent were messages and data transfer transmitted and received between local, OA and region as required by exercise specifics?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent were frequencies available for transmission during the exercise?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent were you able to assess specific polities and procedures for the authorization and tracking of messages?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent did you use ICS Form 213 to document ACS* message traffic?

0% 20% 40% 60% 80% 100% N/A

Objective VII: To what extent were you able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate the service's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate?

ACS* Evaluation Form, page 3 of 3

(2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Medical Clinic Evaluation Form

(Community Health Centers, Medical Office Buildings (MOBs), Urgent Care Facilities and Indian Health Centers)

Please print and submit one evaluation form only for each facility to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Clinic Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the single best answer that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI

Please circle the single best answer that describes the facility.

A. Primary Care Clinic
B. Urgent Care Facility
C. Indian Health Center
D. Other: _____

Please indicate the level of participation of the facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Medical Clinic Evaluation Form, page 2 of 3

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

All Areas

Objective I: To what extent did you succeed in identifying clinic personnel responsible for establishing communication with external medical emergency contacts?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent were you able to identify clinic personnel responsible for activating the clinic Emergency Operations Plan and determine appropriate course of action?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was the facility able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses in emergency operations plans, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

Directly Affected Areas

Objective IV: To what extent was the clinic successful in communicating the facility's response capability for managing surge of walking wounded and worried well patients and communicating that capability to the OA Medical/Health POC or parent facility Incident Commander, and clinic consortia utilizing appropriate communication systems?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was the facility successful in communicating the appropriate course of action to the clinic section chiefs or department leaders?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was the facility able to coordinate response efforts with local city public works, police, fire, ambulance, ACS*, and emergency response teams?

0% 20% 40% 60% 80% 100% N/A

Indirectly Affected Areas

Objective VII: How successful was the facility in assessing the response capability for managing surge of walking wounded and worried well patients (depending on proximity to

earthquake epicenter) and assisting affected clinics with resources, and communicating that capability to the OA Medical/Health POC or parent facility incident commander, and clinic consortia?

0% 20% 40% 60% 80% 100% N/A

Objective VIII: To what extent was the facility successful in communicating the appropriate course of action to the clinic section chiefs or department leaders and staff?

0% 20% 40% 60% 80% 100% N/A

Objective IX: To what extent was the facility able to coordinate response efforts with local city public works, police, fire, ambulance, HAM, and emergency response teams?

0% 20% 40% 60% 80% 100% N/A

All Areas

How successful was the facility in conducting an After Action briefing and identifying the gaps and weaknesses in the Emergency Management Plan?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate the facility's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) Is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Local EMS Agency Evaluation Form

Please print and submit <u>one evaluation form only</u> for each agency to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Clinic Facility Name: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the facility is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI

Was the Medical/Health Branch of the OA EOC activated?

A. Yes
B. No
C. Don't know

Please indicate the level of participation of the facility during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

Local EMS Agency Evaluation Form, page 2 of 3

Objective I: To what extent was the department able to utilize pre-established disaster protocols, evaluate and implement changes in medical control appropriate to the event?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was the department able to provide oversight and system management to hospitals and pre-hospital providers as they responded to the catastrophic events?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was the department able to assist with the coordination of response recourse requests and medical mutual aid?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was the department able to assist in hospitals' assessment of patient bed availability and communicate this to the OA?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was the department able to participate in OA and regional resource allocation decisions?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was the department able to participate in patient tracking efforts?

0% 20% 40% 60% 80% 100% N/A

Objective VII: To what extent was the department able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

How would you evaluate the facility's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review/changes identified

Emergency Medical Services Authority
Statewide Medical & Health Disaster Exercise
November 15 & 16, 2006

Local EMS Agency Evaluation Form, page 3 of 3

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) Is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Public Health Evaluation Form

Please print and submit <u>one evaluation form only</u> for each department to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

Public Health Entity: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the OA is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Circle the level of participation of the OA EOC during the exercise.

A. Full Scale Exercise
B. Functional Exercise
C. Tabletop Exercise
D. Communications Exercise

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

Did you activate the Medical and Health Branch of the EOC?

A. Yes
B. No
C. Don't Know

All Areas:

Objective I: To what extent was the department able to assess the role of the local health department during this disaster?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was the department able to collect accurate and pertinent data from the OA Medical/Health POC, or from healthcare providers, including hospitals, clinics, EMS providers and others?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was the department able to communicate threats and health alerts to healthcare providers, including hospitals, clinics, EMS providers and others?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was the department able to develop risk communication messages consistent with local emergency managers, hospitals and other officials in a rapid and timely manner for internal and external dissemination?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was the department able access and transmit information to region and state medical and health authorities through RIMS and CAHAN?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent were you able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

"Directly Affected Areas":

Objective VII: To what extent was the department able to develop environmental health bulletins to the public regarding water and food safety, coordinating dissemination of these messages through the JIC?

0% 20% 40% 60% 80% 100% N/A

Public Health Evaluation Form, page 3 of 3

All Areas:

How would you evaluate the service's response to the event and initiation of the Emergency Management Plan?

E. Excellent: no changes needed in the Emergency Management Plan
F. Good: minor changes in the system/Emergency Management Plan identified
G. Fair: moderate changes needed in the system/Emergency Management Plan identified
H. Needs improvement: substantial Emergency Management Plan review and changes identified

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) Is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Operational Area (OA) OES Evaluation Form

Please print and submit <u>one evaluation form only</u> for each OA to EMSA (c/o Anne Bybee, 1930 – 9th Street, Sacramento CA 95814 or FAX 916-323-4898) by December 8, 2006. Certificates for Participation will be provided only upon receipt of the Exercise Evaluation.

OA: _____

Address: _____

City: _____ Zip: _____

Disaster Coordinator/Evaluator Name: _____

Telephone #: _____ Fax #: _____

E-mail: _____

Please circle the <u>single best answer</u> that describes in which OES Mutual Aid Region the OA is located (Listed on *PAGE* 111)

A. Region I
B. Region II
C. Region III
D. Region IV
E. Region V
F. Region VI
G. Don't Know

Circle the level of participation of the OA EOC during the exercise.

E. Full Scale Exercise
F. Functional Exercise
G. Tabletop Exercise
H. Communications Exercise

Did you activate the Emergency Management Plan during the exercise?

A. Yes
B. No
C. Don't Know

Did you activate the Medical and Health Branch of the EOC?

A. Yes
B. No
C. Don't Know

OA OES Evaluation Form, page 2 of 4

Did you activate other branches in the OA EOC during the exercise?

A. Yes
B. No

How would you evaluate the department's response to the event and initiation of the Emergency Management Plan?

A. Excellent: no changes needed in the Emergency Management Plan
B. Good: minor changes in the system/Emergency Management Plan identified
C. Fair: moderate changes needed in the system/Emergency Management Plan identified
D. Needs improvement: substantial Emergency Management Plan review and changes identified

All Areas:

Objective I: To what extent was the OA able to assess the OA's ability to collect timely, accurate and appropriate data from participants, including situation reports, status reports, and incident specific RIMS forms?

0% 20% 40% 60% 80% 100% N/A

Objective II: To what extent was the OA able to implement EOC procedures and mechanisms for managing a large scale medical event, including the procurement, management and allocation of scarce resources within the OA?

0% 20% 40% 60% 80% 100% N/A

Objective III: To what extent was the OA able to access, enter, and transmit data via RIMs to regional and state medical and health authorities?

0% 20% 40% 60% 80% 100% N/A

Objective IV: To what extent was the OA able to activate ACS* and pass two-way messages to OA participants, regional providers and the RDMHS?

0% 20% 40% 60% 80% 100% N/A

Objective V: To what extent was the OA Medical/Health POC able to assist in coordinating patient tracking with the hospitals and with any other identified participants?

0% 20% 40% 60% 80% 100% N/A

Objective VI: To what extent was the OA able to conduct an After Action briefing, develop an After Action Report identifying gaps/weaknesses, and implement a corrective action plan?

0% 20% 40% 60% 80% 100% N/A

Directly Affected Areas:

Objective VII: To what extent was the OA able to develop risk communication messages consistent with appropriate public health doctrine in a rapid and timely manner for internal and external dissemination?

0% 20% 40% 60% 80% 100% N/A

Objective VIII: To what extent were the Local EMS Agency and the OA able to assess the OA's ability to receive and manage incoming ASTs and other medical health mutual aid resources?

0% 20% 40% 60% 80% 100% N/A

Objective IX: To what extent was the OA Medical/Health POC able to assist in locating and establishing ACS or FTS to manage the overwhelming number of casualties or patients being evacuated from damaged hospitals?

0% 20% 40% 60% 80% 100% N/A

Objective X: To what extent was the OA able to assess back up resource response systems or techniques to mitigate potential problems associated with at least one system critical to the operation of a health facility, e.g. loss of water, power, computers, sewer, natural gas, etc.?

0% 20% 40% 60% 80% 100% N/A

Indirectly Affected Areas:

Objective XI: To what extent were the Local EMS Agency and the OA able to determine local resources for the reception and transportation of incoming casualties from affected counties and the placement of those patients at local hospitals or other appropriate healthcare facilities?

0% 20% 40% 60% 80% 100% N/A

Objective XII: To what extent were the Local EMS Agency and the OA able to track incoming patients from out of the area?

0% 20% 40% 60% 80% 100% N/A

Objective XIII: To what extent were the Local EMS Agency and the OA able to organize and dispatch ASTs to affected counties as directed?

0% 20% 40% 60% 80% 100% N/A

Objective XIV: To what extent were the Local EMS Agency and the OA able to continue provision of hospital service after receiving a surge of patients from the "Directly Affected Areas"?

0% 20% 40% 60% 80% 100% N/A

OA OES Evaluation Form, page 4 of 4

Objective XV: To what extent were the Local EMS Agency and the OA able to continue to provide ambulance service after sending ASTs to "Directly Affected Areas"?

0% 20% 40% 60% 80% 100% N/A

All Areas:

In general, to what extent were you satisfied with the November Statewide Medical & Health Disaster Exercise?

0% 20% 40% 60% 80% 100% N/A

Additional Comments and Recommendations for the Statewide Medical & Health Disaster Exercise. Please include: (1) Is it the preference to keep the Statewide Exercise in conjunction with the Golden Guardian Exercise or having it separate? (2) What month of the year is ideal to conduct the Statewide Medical/Health exercise? And (3) Do you prefer to have one Exercise Guidebook or a separate Toolkit as in the past?

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Conducting the Exercise: Tips for Hospital Participants

This year, the Statewide Medical & Health Disaster Exercise scenario is providing participants with an opportunity to expand their facility-wide exercise. Many times, the drills and tabletops conducted have focused on the emergency department and emergency services and have not impacted all units and/or departments in the facility. This year, the scenario focuses on the entire healthcare facility and its ability to manage a large influx of patients and address the allocation of scarce resources including staffing, inpatient beds and equipment, supplies and requesting newly developed and allocated trauma and burn caches. The 2006 Medical & Health Disaster Exercise Planning Committee encourages hospitals to involve all units/departments and staff within the hospital to actively participate in the exercise, activate departmental Emergency Management Plans and reach out to other healthcare partners, as well as local ACS* volunteers, EMS, law enforcement, county emergency management, etc. to meet the demands of the surge of patients.

The Statewide Medical & Health Disaster Exercise involves two different scenarios. On November 15th, a 7.9 earthquake occurs in the San Francisco Bay Area. On November 16th the San Bernardino County medical system will conduct its follow up exercise to the detonation of a series of IED episodes that occurred on November 14th, and the regions/State will continue with the earthquake response efforts.

The exercise participants are identified as either from a "Directly Affected Area" (*see page 9*), or an "Indirectly Affected Area".

In the "Directly Affected Areas", patients begin arriving in hospitals and clinics in increasing volume. Should this be an actual event, the hospital would be confronted with a wide variety of clinical care issues while coordinating efforts with other community hospitals and local response agencies (EMS agencies, OES, law enforcement, among others). When planning and executing the exercise, it is recommended that the exercise begins with a rapid increase in patients presenting to the hospital that require high level, long term medical care.

At the "Indirectly Affected Area" facilities, hospitals would be asked to provide mutual aid in any of the following areas: receipt of patients from evacuated facilities; providing staff to travel to Directly Affected Areas; sending surplus equipment and supplies to the "Directly Affected Areas". If planning a full-scale exercise to include receipt of patients from the "Directly Affected Areas", it is recommended that the exercise begins with a rapid influx of patients via ambulance that require high level, long term medical care. If less than a full-scale exercise is preferred, the option might be to build the scenario in coordination with the OA Medical/Health POC and providing mutual aid by sending staff or equipment/supplies to the "Directly Affected Areas".

There are different types of exercises that can be conducted including full scale, functional, tabletop and communication (see glossary for definition of exercises, *page 97*). Each of these exercises can test the response and management of the event.

As stated previously, the scenario and objectives in this document can be modified by any facility or entity participating in the exercise so that it meets individual needs.

The following are some recommendations to increase participation in this exercise:

- Activate the hospital's EOC and HICS or Unified Command (UC) to manage the event and address the policy issues as described in the scenario.
- Incorporate into the activation personnel who may not have previously played a role in the EOC.
- Activate high census plans in all departments and move "live" patients, "live" volunteer patients, or "paper" patients as appropriate to vacate beds and accept new patients.
- If in the San Francisco Bay Area, consider implementing earthquake procedures (security, search, evacuation, structural assessment, etc.) to assist in determining facility priorities, patient care management, staff protection and coordination with local law enforcement.
- If in San Bernardino County, consider implementing bomb threat procedures (security, search or evacuation) to assist in determining facility priorities, patient care management, staff protection and coordinating with local law enforcement.
- If in an "Indirectly Affected Area" simulating the provision of medical mutual aid, consider coordination of activities with the OA Medical/Health POC.
- Review and test Surge Capacity Plans (which should be an Annex to the Emergency Management Plan) where applicable.
- Test the call back (staff notification) systems and lists, update lists and procedures as appropriate.
- Inventory all linen, nutritional supplies (food, water) and housekeeping materials to determine if additional quantities will be needed for the large patient influx and high patient census.
- Based on the scenario and trauma issues, determine the health care disciplines that will be needed for this event and project these numbers for 4, 8, 12, 24 hours and longer.
- Activate internal and external security plans and institute traffic control measures, visitor access and set up perimeter barricades, etc.
- Consider a plan to "lock down" the facility, if appropriate to the events, defining under what authority within the facility or outside of the facility a lock down would be ordered, when and how a "lock down" would occur and when the "lock down" would be discontinued.

- Review the ability to maintain ongoing ED services in the event of a lock-down and the ability to receive ambulance traffic and walk-in patients.
- Assess the specific policies and procedures for authorization and tracking of messages.
- Activate the hospital's ACS* and test message sending and receiving.
- Determine ways in which large numbers of patients requiring specialty care needs can be safely cared for at the facility.
- Arrange for the influx of patients using "live" volunteer patients (or "paper" patients) coming through the Emergency Department as described in the scenario.
- Stage a convergence of volunteers into the facility offering clinical and non-clinical assistance with live persons (or "paper" volunteers). How will the facility deal with and manage these well-meaning volunteers? How will licensing and credentialing issues be dealt with?
- Institute procedures in the business office and patient registration to manage an overwhelming number of patients and implement hospital Information System/ Information Technology (IS/IT) emergency policies and procedures to accommodate the business needs of the facility.
- Determine ways in which to disseminate information to the hospital or campus to maintain stability and decrease panic.
- Activate the media relations or public information officer to respond to multiple media calls for information and/or convergence of media into the facility.
- Assign a room to serve as the incident Command Center (CC) equipped with dedicated phone and/or FAX lines for 'emergency' communications.
- If there is a room designated for Incident Command purposes, consider having access to the outside (via window or door) so ACS* staff can run antenna cable.
- Identify a core group of staff, including a moderator and scribe, with access to a digital recorder or laptop for documenting events for use in After Action reports.
- Advertise and invite partners/agencies/participants well in advance of exercise and hold informational meetings as needed.

These are only a few ideas to help conduct a successful exercise that will engage and involve multiple units/departments. Use imagination and be creative in planning for the 2006 Statewide Medical and Health Disaster Exercise!

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JCAHO Hospital
Emergency Management Drills Standards

Effective July 1, 2006, the revised standard EC.4.20 regarding emergency management drills will require health care organizations to improve the planning and evaluation of emergency management drills. This change is being made to help ensure that the field is conducting emergency management drills rigorously and thoroughly. It is believed that there have been missed opportunities during drills to identify and improve weaknesses. The revised standards were derived from current literature on the characteristics of effective emergency drills and the input of two nationally recognized emergency management experts. Based on this research, the revised standard emphasizes a continuous quality improvement approach to planning, conducting, and evaluating emergency management drills.

Emergency Management Drills (revised EC 4.20)

EC 4.20 Standard

The Hospital regularly tests its emergency management plan.

Elements of Performance for EC.4.20

Number and Types of Exercises

1. The hospital tests its emergency management plan twice a year, either in response to an actual emergency or in a planned exercise.
    a. Staff in freestanding buildings classified as a business occupancy that does not offer emergency services nor is community designated as a disaster-receiving station need to conduct only one emergency preparedness exercise annually.
    b. Table top sessions, though useful, are not acceptable substitutes for exercises.
2. Hospitals that offer emergency services or are community-designated disaster receiving stations conduct at least one exercise a year that includes an influx of actual or simulated patients.
3. Hospitals that have a defined role in the communitywide emergency management program participate in at least one communitywide exercise a year.
    a. Communitywide may range from a contiguous geographic area served by the same healthcare providers, to a large borough, town, city or region.
    b. Exercises for Element or Performance 2 and 3 may be conducted separately or simultaneously.
    c. Table top sessions are acceptable in meeting the community portion of this exercise.

JCAHO Hospital
Emergency Management Drills Standard, continued

Scope of Exercises

1. Planned exercise scenarios that are realistic and related to the priority emergencies identified in the organization's hazard vulnerability analysis.
2. During planned exercises, an individual whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise documents' opportunities for improvement.
3. During planned exercises the hospital monitors at least the following Core Performance areas:

    - Event notification including processes related to activation of the emergency management all hazards command structure.
    - Notification of staff.
    - Notification of external authorities.
    - Communication including the effectiveness of communication both within the hospital as well as with response entities outside of the hospital such as local governmental leadership, police, fire, public health and other healthcare organization within the community.
    - Resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation and security.
    - Patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking.
    - All exercises are critiqued to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.
    - Completed exercises are critiqued through a multi-disciplinary process that includes administration, clinical (including physicians) and support staff.
    - The hospital modifies its emergency management plan in response to critiques of exercises.
    - Planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise (when improvements require substantive resources that can not be accomplished by the next planned exercise, interim improvements must be put in place until final resolution).
    - The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

JCAHO Ambulatory Care Facility Exercise Standards

From the 2005-2006 Comprehensive Accreditation Manual for Ambulatory Care

Standard EC (Environment of Care) 4.10
The organization addresses emergency management.

Rationale for EC.4.10
An emergency in the organization or its community could suddenly and significantly affect the need for the organization's services or its ability to provide those services. Therefore, an organization needs to have an emergency management plan that comprehensively describes its approach to emergencies in the organization or in its community.

Elements of Performance for EC.4.10 (1 and 2 of 21)

1. The organization establishes the following with the community:
    - Priorities among the potential emergencies identified in the hazard vulnerability analysis
    - The organization's role in relation to a community wide emergency management program
    - An "all-hazards" command structure within the organization that links with the community's command structure.
2. The organization develops and maintains a written emergency management plan describing the process for disaster readiness and emergency management and implements when appropriate.

Standard EC.4.20
The organization conducts drills regularly to test emergency management.
Elements of Performance for EC.4.20

1. The organization tests the response phase of its emergency management plan twice a year, either in response to an actual emergency or in planned drills.*

   Note 1*: Staff in each freestanding building classified as a business occupancy (as defined by the LSC) that does not offer emergency services nor is community-designated as a disaster-receiving station need to participate in only one emergency management drill annually. Staff in areas of the building that the organization occupies must participate in this drill.*
   Note 2*: Tabletop exercises, though useful in planning or training, are* ***not*** *acceptable substitutes for drills.*

2. Organizations that offer emergency services or are community designated disaster receiving stations must conduct at least one drill a year that includes an influx of volunteers or simulated patients.

3. All drills are critiqued to identify deficiencies and opportunities for improvement.

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Facts About Earthquakes

Scenario for a M7.9 Earthquake on the San Andreas Fault in Central California GGEX06 and Statewide Medical/Health Exercise

(Richard Eisner, FAIA, Regional Administrator, OES Coastal Region)

Background

The scenario for a M7.9 Earthquake developed for the GGEX06 is based on a repeat of the 1906 earthquake on the San Andreas Fault. The 1906 earthquake produced damage in 19 central California counties, extending from San Juan Batista to Cape Mendocino, and into the San Joaquin Valley. The United States Geological Survey (USGS) estimates that the scenario earthquake has 21% probability of occurring before 2032.

A recurrence of the 1906 earthquake is NOT the worst case scenario for damage, nor is it the most likely damaging earthquake to occur in either central or southern California. A recurrence of the 1868 Hayward/Rogers Creek earthquake, on a fault directly beneath the eastern edge of the San Francisco Bay, has an estimated probability of occurrence of greater than 27% within the next 30 years. A Hayward/Rogers Creek earthquake would produce greater damage, loss of life and injuries and economic losses than the proposed scenario.

The scenario depicts the interrelationships and dependencies between damage to structures, resulting displaced households and significant shelter demand, deaths and injuries, disruption of electric power and water services, damage and disruption to freeway and local roads, damage to hospitals, fire stations, schools and emergency operations centers, and debris generated.

Ground Motions for the Scenario

The ground motions used in the scenario were developed by the USGS, based on observed damage in 1906 and projected ground shaking where no records were available. The ground motions are depicted as a Shake Map that represents intensity of shaking, the frequency of the shaking and the duration of strong shaking. The USGS has produced a suite of Shake Maps for possible earthquakes in California that are available for loss estimation, scenarios and exercises.

The Shake Map for the GGEX06 can be downloaded from:

http://quake.wr.usgs.gov/research/strongmotion/effects/shake/SanAndreas_10_se/intensity.html

Facts About Earthquakes, continued

Estimating Damage and Losses

Damage, casualties and losses for GGEX06 were estimated using HAZUS™, loss estimation software developed by the Federal Emergency Management Agency (FEMA), augmented where additional building inventory and data on damage were available. The ground motion Shake Map was used by HAZUS™ to produce estimated damage to critical facilities, commercial and residential structures, injuries and fatalities caused by the collapse of those structures, damage to lifelines and transportation infrastructure and economic loss. (HAZUS uses engineering parameters of ground shaking Peak Ground Acceleration [PGA] and Peak Ground Velocity [PGV] to calculate damage to structures).

Estimates of hospital performance were derived from data provided by the Office of Statewide Health Planning and Development (OSHPD) facility assessment survey. Both the estimates of transportation damage and hospital performance may be conservative (overestimating damage). For transportation damage, the HAZUS™ database of bridges (National Bridge Inventory of the US Department of Transportation) does not reflect the CalTrans seismic retrofit program. For health and medical facilities, the OSHPD survey may not reflect the actual structural performance of hospitals. However, in both cases, the HAZUS™ scenarios are credible initial estimates of damage to facilities, which in an actual earthquake event, would require site specific structural assessments to determine actual building performance.

GGEX06 data includes the following (see chart on *page 89*):

Effects of Earthquake on region end of Day 1 (although all will not necessarily be realized at that time)

- 35 fire stations damaged
- 500 to 600 fires in region, 100 of which are in San Francisco
- 789,000 households without power
- Over 1 million households without water
- 13,000 injuries requiring hospitalization
- 3,332 deaths, including those trapped in debris
- 54 hospitals are damaged, of which 27 are extensive or complete
- 344 schools are damaged, of which 55 are extensive or complete
- 77 Police, fire and EOCs are damaged, of which 19 are extensive or complete
- 1,185 bridges are damaged, of which 948 are extensive or complete
- Extensive damage to Roadways near the fault and adjacent to the Bay, slews, streams
- 200,000 to 300,000 displaced households
- 60,000 to 120,000 persons requiring short-term shelter
- 463,254 buildings damaged, of which 37,025 are complete; over $120 billion of building losses
- 25 to 40 million tons of debris generated
- Direct and indirect losses will exceed $150 billion

GGEX06
Estimated Damages and Loss

Building Type	Total No. of Buildings	No. of Buildings with Structural Damage		
		Moderate	Extensive	Complete
Residential Buildings	2,078,108	317,065	81,664	33,083
Commercial Buildings	51,579	12,584	6,919	3,132
All Buildings	2,141,252	335,700	90,528	37,025
Essential Facility Type	**Total No. of Facilities**	**No. of Facilities with Structural Damage**		
		Moderate	**Extensive**	**Complete**
Hospitals	99	27	15	12
Schools	2544	289	42	13
Police Stations, Fire Stations, and /or EOCs	355	58	14	5
Bridge Type	**Total No. of Bridges**	**No. of Bridges with Structural Damage**		
		Moderate	**Extensive**	**Complete**
Highway Systems	3748	238	338	20
Building Type	**Total Exposure ($ billions)**	**Economic Loss due to Ground Shaking/Failure**		
		Building	**Contents**	**Total (with BI)**
Residential Buildings	579.8	56.8	7.7	67.1
Commercial Buildings	158.4	26.8	6.1	40.4
All Buildings	791.0	91.9	16.5	119.0
Casualties - Deaths and Injuries	**Total Population**	**Casualties by Time of Day**		
		2:00 PM	**2:00 AM**	
Treat & Release Injuries	7,039,362	43,731	28,777	
Serious (Hospital) Injuries		12,254	7,686	
Trapped Needs Rescue		1,718	923	
Immediate Deaths		3,322	1,770	
Displaced Households and Temporary Public Shelter	**Total No. of Households**	**No. of Displaced Households**	**People Needing Temporary Shelter**	
	2,557,158	241,059	125,529	
Lifeline Performance	**Total No. of**	**Households without Service**		

	Households	Day 1	Day 7	Day 30
Potable Water Systems	2,557,158	1,828,000	1,279,000	256,000
Electric Power Systems		789,000	229,000	59,000
Fire Following Earthquake	**Total No. of Census Tracts**	**Number of Ignitions**		
	1457	569		

Facts About Improvised Explosive Devices (IEDs)

(In support of the San Bernardino County event)

An IED can be almost anything with any type of material and initiator. It is a 'homemade' device that is designed to cause death or injury by using explosives alone or in combination with toxic chemicals, biological toxins, or radiological material. IEDs can be produced in varying sizes, functioning methods, containers and delivery methods. IEDs can utilize commercial or military ordnance and ordnance components.

They are unique in nature because the IED builder has had to improvise with the materials at hand. Designed to defeat a specific target or type of target, they generally become more difficult to detect and protect against as they become more sophisticated. IEDs fall into three types of categories:

1. Package Type IED
2. Vehicle–Borne IED (VBIEDs)
3. Suicide Bomb IED

Though they can vary widely in shape and form, IEDs share a common set of components and consist of the following:

- An initiation system or fuse;
- Explosive fill;
- A detonator;
- A power supply for the detonator; and
- A container.

Usually, IEDs are of crude design. However, terrorist groups have been known to produce sophisticated devices. Since these devices are nonstandard, there are no specific guidelines for explosive ordnance disposal personnel to use to positively identify or categorize them. Highly sophisticated IEDs have been constructed from arming devices scavenged from conventional munitions and easily purchased electronic components, as well as consumer devices such as mobile phones. The degree of sophistication depends on the ingenuity of the designer and the tools and materials available. Today's IEDs are extremely diverse and may contain any type of firing device or initiator, plus various commercial, military, or contrived chemical or explosive fillers.

Injuries sustained as a result of an IED are caused by the pressure wave of the primary blast, the penetrating and non-penetrating wounds of the secondary blast, and the injuries associated with being thrown some distance. The medic or lifesaver must be aware of multiple wounds and combination wounds and must know how to thoroughly treat the patient. Additionally, treatment of shock becomes important.

Facts about Crush Injuries

Acts of nature like hurricanes, tornadoes or earthquakes are going to cause a significant increase in crush injuries. The time it will take for survivors to be found will contribute to the incidence of crush syndrome.

Crush injury is defined as a mechanism of injury in which skeletal muscle tissue is compressed by high pressure forces. **Crush syndrome** is a systemic disorder that results in metabolic disturbances resulting from the crush of skeletal muscle. For crush syndrome to occur, the skeletal muscle must be exposed to the high pressure forces for an at least four hours. In an earthquake scenario, it would not be uncommon to find people trapped after an extended period of time.

Because of the continuous pressure and restriction to circulation, the crushed skeletal muscle tissue undergoes necrosis or tissue death. Once the pressure has been removed from the skeletal muscle, toxins are released into the circulatory system. The greater the skeletal muscle involved, the greater the amount of toxin released into the circulatory system.

Toxins include:

- Lactic acid (from anaerobic respiration)
- Myoglobin (from muscle protein)
- Phosphate and potassium (from cellular death)
- Uric acid (from protein breakdown).

Crush syndrome can present with:

- Compartment syndrome
- Hypovolemic shock
- Hyperkalemia
- Hypocalcemia
- Metabolic acidosis
- Renal failure

Treatment of crush syndrome can include:

- Oxygen and skeletal stabilization
- Cardiac monitoring
- Fluid resuscitation prior to release of compression
- Morphine sulfate for pain relief if no hypotension
- dopamine
- If hyperkalemia suspected:
    - Albuterol
    - Calcium chloride
    - Sodium bicarbonate

The amount of skeletal muscle involved in the crush injury is directly proportional to the severity of the crush syndrome. The severity of the crush syndrome dictates the complexity of care needed in the hospital setting and subsequent hospital course.

Additional Resource References

Earthquakes:

USGS, *Putting Down Roots in Earthquake Country*
http://pubs.usgs.gov/gip/2005/15/

USGS Earthquake Information
http://quake.wr.usgs.gov/

USGS Shake Maps
http://www.cisn.org/shakemap/nc/shake/

California Integrated Seismic Network (CISN) Real-time Earthquake Information and Notification
http://www.cisn.org/services.html

CISN Display Notification and Shake Maps
http://www.cisn.org/software/cisndisplay.htm

General Earthquake Risk to San Francisco Bay Area:
http://quake.wr.usgs.gov/research/seismology/wg02/

Epidemiology of Traumatic Injuries from Earthquakes,
http://epirev.oxfordjournals.org/cgi/content/full/27/1/47

Improvised Explosive Devices:

Fire and Emergency Services Preparedness Guide for the Homeland Security Advisory System, 1/2004, http://www.emergency.com/2004/hsas-guide.pdf

Improvised Explosive Devices (IEDs) / Booby Traps,
http://www.globalsecurity.org/military/intro/ied.htm

Minimum Personal Protective Equipment (PPE) for Ambulance Personnel, Guidelines #216, California EMS Authority, http://www.emsa.ca.gov/aboutemsa/emsa_pubs.asp

Management of Crush Related Injuries After Disasters,
http://content.nejm.org/content/full/354/10/1052

Preparing for a Terrorist Bombing – A Common Sense Approach, Fact Sheet, CDC, 7/19/05,
http://www.bt.cdc.gov/masstrauma/pdf/preparingterroristbombing.pdf

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Acronyms

AABB	**American Association of Blood Banks**
ACS	**Alternate Care Sites**
ACS*	**Auxiliary Communications Systems**
AEOC	**Area Emergency Operations Center**
ARC	**American Red Cross**
ARES	**Amateur Radio Emergency Services**
CAHAN	**California Health Alert Network**
CARES	**California Amateur Radio Emergency Services**
CBBS	**California Blood Bank Society**
CBO	**Community Based Organization**
CC	**Command Center**
CDC	**Centers for Disease Control and Prevention**
CDHS	**California Department of Health Services**
CERT	**Community Emergency Response Team**
CHA	**California Hospital Association**
CHP	**California Highway Patrol**
CISN	**California Integrated Seismic Network**
CNG	**California National Guard**
DOC	**Departmental Operations Center**
DWR	**Department of Water Resources**
EC	**Environment of Care**
ED	**Emergency Department**
EMS	**Emergency Medical Services**
EMSA	**Emergency Medical Services Authority**
EMT	**Emergency Medical Technician**
EOC	**Emergency Operations Center**
ETA	**Estimated Time of Arrival**
FCC	**Federal Communications Commission**
FBI	**Federal Bureau of Investigation**
FEMA	**Federal Emergency Management Agency**
FTS	**Field Treatment Site**
GGEX06	**Golden Guardian Exercise 2006**
HEICS	**Hospital Emergency Incident Command System (with version IV will be replaced with HICS)**
HICS	**Hospital Incident Command System**
HRSA	**Health Resources and Services Administration**
IC	**Incident Command or Incident Commander**
ICS	**Incident Command System**
IED	**Improvised Explosive Device**
IS	**Information Services**
IT	**Information Technology**
JCAHO	**Joint Commission on Accreditation of Healthcare Organizations**

JEOC	**Joint Emergency Operations Center**
JIC	**Joint Information Center**
LEMSA	**Local EMS Agency**
MHOAC	**Medical Health Operational Area Coordinator**
MMI	**Modified Mercalli Intensity (referring to earthquakes)**
MMRS	**Metropolitan Medical Response System**
MOB	**Medical Office Building**
MRC	**Medical Reserve Corps**
MSELs	**Master Sequence of Events Listing**
NACS	**Neighborhood Alternate Care Sites**
NDMS	**National Disaster Medical System**
NIMS	**National Incident Management System**
NPC	**Non-Structural Performance Category**
OA	**Operational Area**
OES	**(California Governor's) Office of Emergency Services**
OSPHD	**Office of Statewide Health Planning and Development**
PGA	**Peak Ground Acceleration**
PGV	**Peak Ground Velocity**
PIO	**Public Information Officer**
POC	**Point of Contact**
RACES	**Radio Amateur Civilian Emergency Services**
REOC	**Regional Emergency Operations Center**
RDMHC	**Regional Disaster Medical Health Coordinator**
RDMHS	**Regional Disaster Medical Health Specialist**
RIMS	**Response Information Management System**
RN	**Registered Nurse**
SEMS	**Standardized Emergency Management System**
SNF	**Skilled Nursing Facility**
SOC	**State Operations Center**
SPC	**Structural Performance Category**
UC	**Unified Command**
US&R	**Urban Search & Rescue**
USGS	**U.S. Geological Survey**
VBIED	**Vehicle-Borne Improvised Explosive Device**
WCATWC	**West Coast and Alaska Tsunami Warning Center**

Glossary of Terms

Affected Areas	"Directly Affected Areas" are any areas identified as being directly affected by the events in the California Office of Homeland Security's Golden Guardian Exercise 2006 (GGEX06) scenario (either an earthquake or an IED). The counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Sonoma, Santa Cruz, and San Bernardino represent these areas. "Indirectly Affected Areas" represents all other OAs in the State of California with the intent that they will simulate the provision of medical mutual aid to the "Directly Affected Areas".
Alternate Care Sites (ACS)	ACSs in California are designed to treat patients who need more extensive care such as hydration, ventilatory assistance, or pain management. Patients admitted to an ACS may be admitted for end of life care utilizing the hospice concept. The ACS concept also facilitates co-mingling of patients with the same infectious process or exposure.
Auxiliary Communications Services (ACS*)	The Auxiliary Communications Service (ACS*) is an emergency communications unit that provides State and local government with a variety of professional unpaid [volunteer] skills, including administrative, technical and operational for emergency tactical, administrative and logistical communications. ACS* works with agencies and cities within the OA, neighboring governments and the State OES Region. Its basic mission is the emergency support of civil defense, disaster response and recovery with telecommunications resources and personnel. **ARES: The Amateur Radio Emergency Service (ARES)** consists of licensed amateurs who have voluntarily registered their qualifications and equipment for communications duty in the public service when disaster strikes. **CARES: California Amateur Radio Emergency Services** CARES is specifically tasked to provide amateur radio communications support for the medical and health disaster response to state government. **RACES: Radio Amateur Civilian Emergency Services** RACES is a local or state government program established by a civil defense official. It becomes operational by: 1) appointing a radio officer; 2) preparing a RACES plan; and 3) training and utilizing Federal Communications Commission (FCC) licensed Amateur Radio operators. RACES, whether part of an ACS* or as a stand alone unit, is usually attached to a state or local government's emergency preparedness office or to a department designated by that office, such as the sheriff's or communications department.

California Blood Bank Society (CBBS)	An organization of individuals who serve in all aspects of blood collection and transfusion. CBBS blood centers are primarily designated as community blood centers; however, some centers are affiliated with ARC or United Blood Services. The CBBS Disaster Plan extends nationally to an Inter-Agency Task Force in the event of major disasters or acts of terrorism.
Emergency	A condition of disaster or of extreme peril to the safety of persons and property caused by such conditions as air pollution, fire, flood, hazardous material incident, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestations or disease, an earthquake, volcanic eruption or terrorist event.
Emergency Management	The organized analysis, planning, decision making, assignment and coordination of available resources to the mitigation of, preparedness for, response to or recovery from emergencies of any kind, whether from man-made attack or natural sources.
Emergency Operations Center	A centralized location from which emergency operations can be directed and coordinated.
Exercise	**Communications:** The communications exercise is designed to test and evaluate communication systems, including lines and methods of communicating during a disaster. Alternative communication systems can also be tested, including amateur radio, cell and satellite systems, among others. **Tabletop:** An exercise that takes place in a classroom or meeting room setting. Situations and problems presented in the form of written or verbal questions generate discussions of actions to be taken based upon the emergency management plan and standard emergency operating procedures. The purpose is to have participants practice problem solving and resolve questions of coordination and assignment in a non-threatening format, under minimal stress. **Functional:** The functional exercise is an activity designed to test or evaluate the capabilities of the disaster response system. It can take place in the location where the activity might normally take place, such as the command center or incident command post. It can involve deploying equipment in a limited, function-specific capacity. This exercise is fully simulated with written or verbal messages. **Full Scale:** This type of exercise is intended to evaluate the operational capability of emergency responders in an interactive manner over a substantial period of time. It involves the testing of a major portion of the basic elements existing in the emergency operations plans and organizations in a stress environment. Personnel and resources are mobilized.

Field Treatment Site (FTS)	Soft-sided (tent) structures built and utilized for emergency situations where fixed structure medical facilities are not available or are not adequate to meet the community's emergency medical care needs.
Hospital Incident Command System (HICS)	HEICS/HICS is an emergency management system that employs a logical, unified management (command) structure, defined responsibilities, clear reporting channels and a common nomenclature to help unify hospitals with other emergency responders. Information on HEICS/HICS can be obtained through the California EMSA website at www.emsa.ca.gov. The current version HEICS III has been under revision and the fourth version will be known as the Hospital ICS or HICS. Although HICS is scheduled for public release this fall (2006), it is not expected that hospitals will have it implemented in their facilities in time for this exercise. Hospitals should use HEICS Version III until they receive HICS Version IV training.
Health Resources & Services Administration (HRSA)	A subdivision of the US Dept. of Health & Human Services, HRSA provides funding and directs programs that improve the Nation's health by expanding access to comprehensive, quality health care. HRSA administrates the National Bioterrorism Hospital Preparedness Program to improve healthcare response to terrorism events and natural disasters.
Incident Command System (ICS)	The nationally used standardized on-scene emergency management concept is specifically designed to allow its user(s) to adopt an integrated organizational structure equal to the complexity and demand of single or multiple incidents without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures and communications operating within a common organizational structure, with the responsibility of managing resources to effectively accomplish stated objectives pertinent to an incident.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	The Joint Commission evaluates and accredits nearly 15,000 health care organizations and programs in the United States. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards-setting and accrediting body in health care.
Long-Term Care Facilities	A collective term for healthcare facilities designated for the care and treatment of patients or residents requiring rehabilitation or extended care for chronic conditions. The Department of Health Services, Licensing and Certification Division licenses these facilities.
Medical and Health OA Coordinator (MHOAC)	The Medical Health Operational Area Coordinator (MHOAC) is responsible for coordinating mutual aid resource requests, facilitating the development of OA Medical/Health response plans and implementing the Medical/Health plans during a disaster response. During a disaster, in most OAs, the MHOAC directs the Medical/Health branch of the OA EOC and establishes priorities for Medical/Health response and requests. This coordinator was formerly known as the OA Disaster Medical/Health Coordinator.

Modified Mercalli Scale	This scale is composed of 12 increasing levels of intensity that range from imperceptible shaking to catastrophic destruction, is designated by Roman numerals. It does not have a mathematical basis; instead it is an arbitrary ranking based on observed effects. The Modified Mercalli Intensity value assigned to a specific site after an earthquake has a more meaningful measure of severity to the nonscientist than the magnitude because intensity refers to the effects actually experienced at that place. After the occurrence of widely-felt earthquakes, the Geological Survey mails questionnaires to postmasters in the disturbed area requesting the information so that intensity values can be assigned.
Neighborhood Alternate Care Sites (NACS)	NACS is designed to be the entry point into the medical system for casualties, asymptomatic exposed and non-exposed individuals who present for care when the system is activated. The purpose is to keep non-critical victims away from local Emergency Departments. Basic triage is performed. Medical treatment is limited to advanced first aid, distribution of prophylactic mediations, self-help information and instructions. Medical stabilization may be performed for those needing transfer to an ACS or a hospital.
National Incident Management System (NIMS)	Developed under Homeland Security Presidential Directive 5, provides a consistent nationwide approach for federal, state, local and tribal governments to work effectively to prepare for, respond to and recover from domestic incidents. California has incorporated NIMS into the State's SEMS process.
Operational Area (OA)	An intermediate level of the State emergency services organization, consisting of a county and all political subdivisions within the county.
OA Medical/Health POC	Disaster planning in the Medical/Health discipline in California has been moving toward a single point of contact (POC) for communications and coordination of resources within the Operational Area (OA). While individual OAs may have different approaches, reporting structures, position descriptions, and names or acronyms for Medical/Health Emergency Operations Centers (EOCs), for the purpose of this document the term OA Medical/Health POC is used as a generic indicator for consistency and clarity. This term is used throughout the Guidebook to denote either the person or the EOC branch responsible for coordinating Medical/Health disaster response.
Regional Emergency Operations Center (REOC)	The first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the OAs and coordinates with the SOC.

Regional Disaster Medical and Health Coordinators (RDMHC)	At the regional level, EMSA and the California Department of Health Services (CDHS) jointly appoint the Regional Disaster Medical Health Coordinator (RDMHC) whose responsibilities include supporting the mutual aid requests of the MHOAC for disaster response within the region and providing mutual aid support to other areas of the state in support of the state medical response system. The RDMHC also serves as an information source to the state medical and health response system.
Regional Disaster Medical Health Specialist (RDMHS)	A full-time position funded by EMSA and CDHS to provide the day-to-day planning and coordination of medical and health disaster response in the six mutual aid regions. During disaster response, the RDMHS is the key contact for OAs to request and/or to provide medical and health resources.
Richter Magnitude Scale	The Richter magnitude scale was developed in 1935 by Charles F. Richter of the California Institute of Technology as a mathematical device to compare the size of earthquakes. The magnitude of an earthquake is determined from the logarithm of the amplitude of waves recorded by seismographs. Adjustments are included in the magnitude formula to compensate for the variation in the distance between the various seismographs and the epicenter of the earthquakes. On the Richter Scale, magnitude is expressed in whole numbers and decimal fractions.
Response Information Management System (RIMS)	RIMS is an Internet based information management system and consists of a set of databases designed to collect information on the disaster situation, communicate action plans and receive mission requests. RIMS is accessed and utilized by OAs, regional and State governmental agencies only.
Standardized Emergency Management System (SEMS)	The emergency management system identified by California Government code 8607 for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the ICS and is intended to standardize response to emergencies in the State.
State Operations Center (SOC)	Established by OES to oversee, as necessary, the REOC, and is activated when more than one REOC is opened. The SOC establishes overall response priorities and coordinates with federal responders.

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OA Medical/Health Exercise Contacts

(Note: some counties may not be participating in the Statewide Exercise in 2006, but remain on this list as a resource for future reference)

COUNTY	CONTACT NAME, TITLE & ADDRESS	CONTACT INFORMATION
Alameda	Jim Morrissey Alameda EMS 1000 San Leandro Blvd. Ste 100 San Leandro, CA 94577	Phone: 510-618-2036 Fax: 510-618-2099 Pager: 415-208-0936 Email: jim.morrissey@acgov.org
Alpine Amador Calaveras Stanislaus	Doug Buchanan Deputy Director Mountain Valley EMS 1101 Standiford Avenue Modesto, CA 95350	Phone: 209-529-5085 Fax: 209-529-1496 Email: dbuchanan@mvemsa.com
Butte	Dr. Mark Lundberg Health Officer 202 Mira Loma Oroville, CA 95965	Phone: 530-538-7581 Fax: 530-538-2165 Email: mlundberg@buttecounty.net
Colusa	Georgeanne Hulbert 251 E. Webster Street Colusa, CA 95932	Phone: 530-458-0380 Fax: 530-458-4136 Email: ghulbert@colusadhhs.org
Contra Costa	Dan Guerra Contra Costa EMS 1340 Arnold Drive, Ste. 126 Martinez, CA 94590	Phone: 925-646-4690 Fax: 925-646-4379 Email: DGuerra@hsd.cccounty.us
Del Norte	Peter Esko Del Norte County Health Dept. 880 Northcrest Drive Crescent City, CA 95531	Phone: 707-464-3191 x 295 Fax: 707-465-1792 Email: pesko@co.del-norte.ca.us
El Dorado	Chris Weston or Richard Todd Public Health Dept. Preparedness 15 Placerville Drive, Suite R Placerville, CA 95667	(Chris) Phone: 530-621-6252 Cell: 530-919-0831 (Todd) 530-621-6505 Fax: 530-621-4781 Email: cweston@co.el-dorado.ca.us; rtodd@co.el-dorado.ca.us
Central California EMS Agency (Fresno, Kings, Madera, Tulare)	Lee Adley PO Box 11867 Fresno, CA 93775	Phone: 559-445-3387 Fax: 559-445-3205 Email: Ladley@fresno.ca.gov
Glenn	Grinnell Norton Public Health 240 N. Villa Avenue Willows, CA 95988	Phone: 530-934-6588 Fax: 530-934-6463 Email: gnorton@glenncountyhealth.net

OA Medical/Health Exercise Contacts

Humboldt	Clarke Guzzi Humboldt Public Health 529 "I" St. Eureka, CA 95510	Phone: 707-268-2187 Fax: 707-445-6097 Email: cguzzi@co.humboldt.ca.us
Imperial	John Pritting 935 Broadway El Centro, CA 92243	Phone: 760-482-4468 Fax: 760-482-4519 Email: johnpritting@imperialcounty.net
Inyo	Tamara Cohn PO Box Drawer H Independence, CA 93526	Phone: 760-878-0232 Fax: 760-878-0266 Email: inyohealth@qnet.com
Kern	Russ Blind Senior Coordinator 1400 H Street Bakersfield, CA 93301	Phone: 661-868-5201 Fax: 661-322-8453 Email: blindr@co.kern.ca.us
Lake	Craig McMillan Lake Co. Dept. of Health 922 Bevins Court Lakeport, CA 95453	Phone: 707-263-1090 Fax: 707-262-4280 Email: craigm@co.lake.ca.us
Lassen	Chip Jackson OES 220 S. Lassen, Suite 1 Susanville, CA 96130	Phone: 530-251-8222 Fax: 530-257-9363 Email: sheriff@co.lassen.ca.us
Los Angeles	Gertha Benson Disaster Preparedness Coordinator 5555 Ferguson Drive, Suite 220 Commerce, CA 90022	Phone: 323-869-8041 Fax: 323-869-8065 Email: gbenson@ladhs.org
Marin	Diane Claytor EMS Administrator 161 Mitchell Blvd., Suite 100 San Rafael, CA 94903 Steven Hancock Asst. Director, OES 3501 Civic Center Drive San Rafael, CA 94903	Phone: 415-499-6833 Fax: 415-499-3747 Email: dclaytor@co.marin.ca.us Phone: 415-499-6586 Fax: 415-499-7450 Email: shancock@co.marin.ca.us
Mariposa	Dana Tafoya Mountain Valley EMS 1101 Standiford Ave, Suite D-1 Modesto, CA 95350	Phone: 209-966-3689 Fax: 209-966-4929 Email: dtafoya@mvemsa.com
Mendocino	Kent Coxon Coastal Valley EMS 475 Aviation Blvd., Ste 200 Santa Rosa CA 95403	Phone: 707-565-6501 Fax: 707-565-6510 Email: kcoxon@sonoma-county.org
Merced	Ron Duran EMS Specialist 260 E. 15th Street Merced, CA 95340	Phone: 209-381-1260 Fax: 209-381-1259 Email: rduran@co.merced.ca.us

OA Medical/Health Exercise Contacts

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Mono	Christina DeGeorge POB 3329 437 Old Mammoth Rd., #Q Mammoth Lakes, CA 93546	cdegeorge@mono.ca.gov Phone: 760-924-1829 Fax: 760-924-1831 E-mail: cisaacs@mono.ca.gov
Monterey	John Sherwin Monterey EMS 19065 Portola Dr. Ste I Salinas, CA 93908	Phone: 831-755-5013 Fax: 831-455-0680 Email: sherwinj@co.monterey.ca.us
Napa	Bonny Martignoni Coastal Valley EMS/Napa 1721 First St. Napa, CA 94559	Phone: 707-253-4345 Fax: Fax: 707-259-8112 Email: bmartign@co.napa.ca.us
Nevada	Andrea Straatemeier Community Health 10433 Willow Valley Road Nevada City, CA 95959	Phone: 530-265-7174 Fax: 530-265-1426 Email: henry.foley@co.nevada.ca.us
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Placer	Young Rodriguez Placer County OES 2968 Richardson Street Auburn, CA 95603	Phone: 530-886-5300 Fax: 530-886-5343 Email: yrodrigu@placer.ca.gov
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Sacramento	Bruce Wagner Sacramento Co. EMS 9616 Micron Avenue, Suite 635 Sacramento, CA 95827	Phone: 916-875-9753 Fax: 916-875-9711 Email: wagnerems@msn.com
San Benito	Jim Clark San Benito County, EMS 1111 San Felipe Road, Suite 102 Hollister, CA 95023	Phone: 831-636-4066 Fax: 831-636-4037 Email: james@sanbenitoco.org

OA Medical/Health Exercise Contacts

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OA Medical/Health Exercise Contacts

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Sonoma	Kent Coxon Coastal Valley EMS 475 Aviation Blvd., Ste 200 Santa Rosa CA 95403	Phone: 707-565-6501 Fax: 707-565-6510 Email: kcoxon@sonoma-county.org
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OES Auxiliary Communications System (ACS*) Contacts

HQ/Inland Region/Mutual Aid Regions III, IV & V

Hal O'Brien
SOCC Operations Officer
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R: 916-863-1949 C: 916-532-7488
W: 916-874-8793 or 8891 WP: 916-901-1625
Alt P: 916-697-4617 Nextel 916-826-5402
E-mail: halobrien@comcast.net
or o'brienh@saccounty.net or hsobrien@sacsheriff.com

Mutual Aid Region III Asst. ACS Officer
Richard White
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P: 530-390-1477
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Email Alt: warehouseboss@yahoo.com

Acting Mutual Aid Region V ACS Officer
Guss Keith
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Southern Region

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W: 760-753-2298 [2]
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Mutual Aid Region I ACS Officer
Gary Rotter
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W: 310-524-7672 [2] WF: 310-524-5515
E-mail: GR120994@ncr.com

Mutual Aid Region VI ACS Officer
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F: 951-303-9245
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OES Auxiliary Communications (ACS*) Contacts, page 2

Coastal Region

Coastal Region ACS Officer
Dave Larton
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E-mail: Dlarton@yahoo.com or
Dave.Larton@oes.ca.gov

Mutual Aid Region II North ACS Officer
(Del Norte, Humboldt, Mendocino, Lake, Marin, Napa, Solano and Sonoma)
Ken McTaGGEX06art
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W: 707-996-8458 WF: 707-996-8550
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Mutual Aid Region II South ACS Officer
(San Francisco, San Mateo, Contra Costa, Alameda, Santa Clara, Santa Cruz, San Benito and Monterey)
James Aspinwall
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R: 408-371-6242 W: 408-828-8100
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STATE OES:
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Asst. Chief, Telecommunications
Inland Region Telecommunications Coordinator
State/Inland Region/HQ ACS Coordinator
Governors Office of Emergency Services
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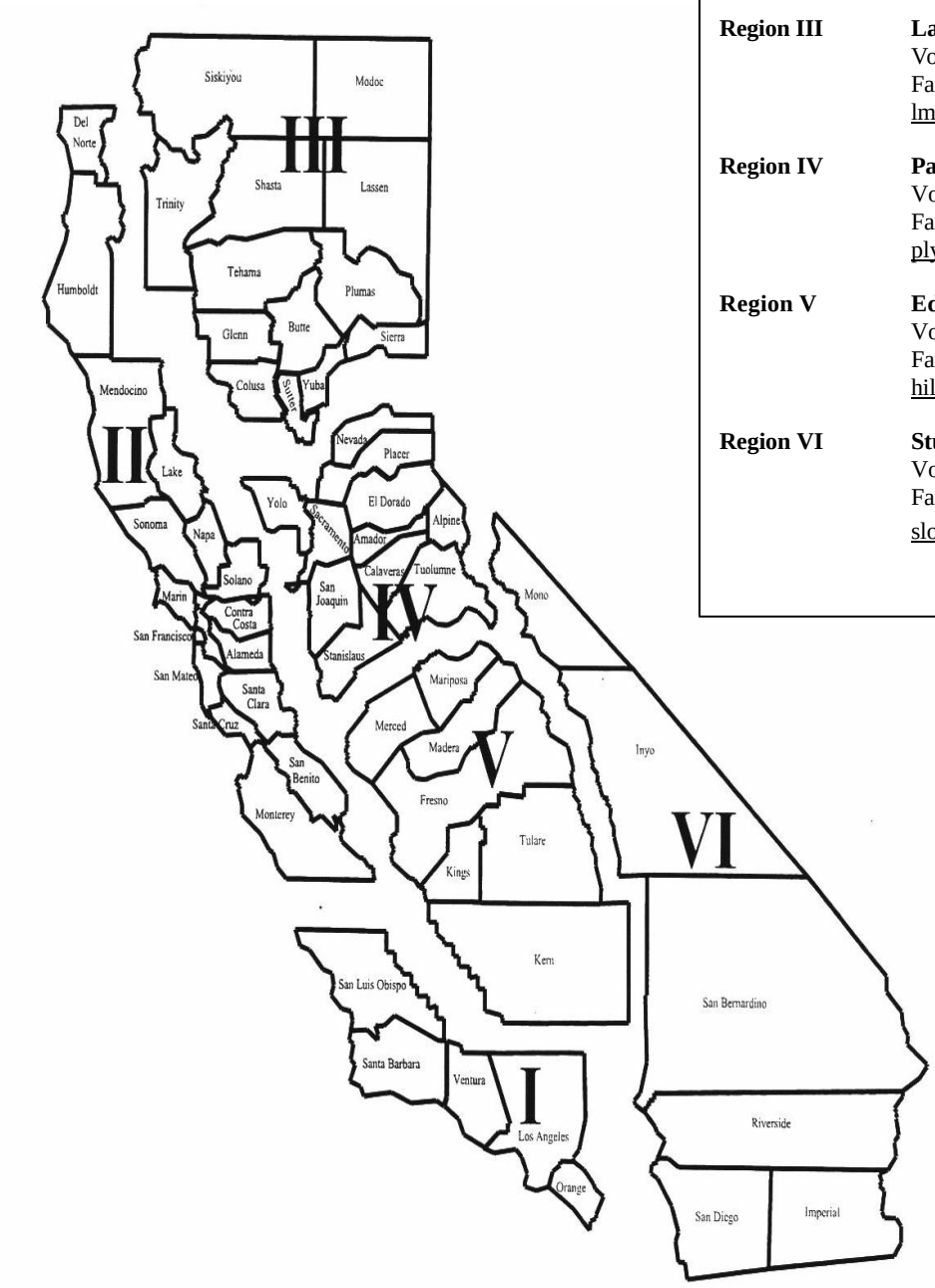
OES Mutual Aid Regional Map and RDMHS Staff Contact Information



Region 1	**Bryan Hanley** Voice (562) 941-5338 Fax (562) 906-0045 bryanhanley@ladhs.org
Region II	**Barbara Center** Voice (925) 646-4690 Fax (925) 646-4379 bcenter@hsd.co.contra-costa.ca.us
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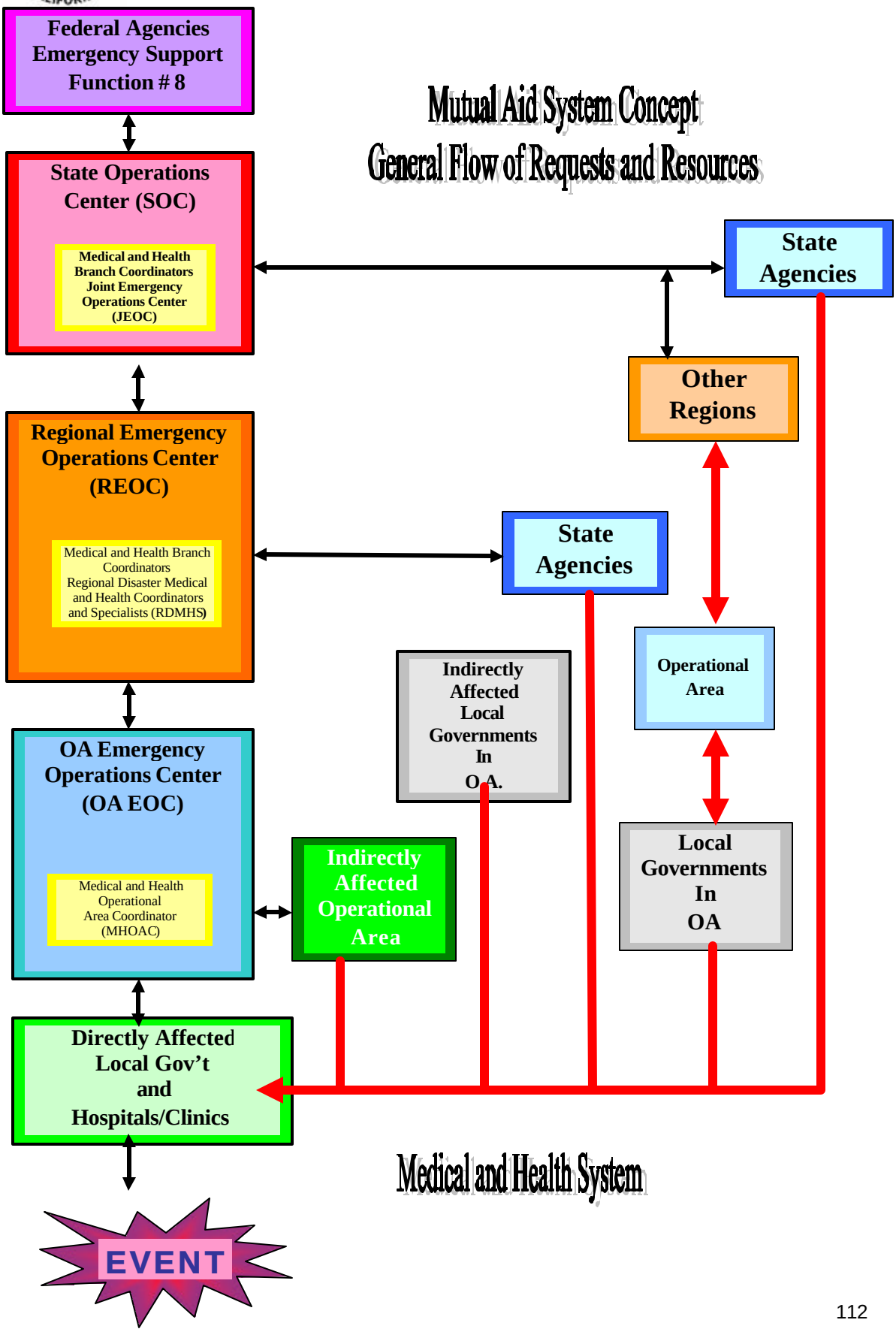
Region V	**Ed Hill** Voice (661) 868-5201 Fax (661) 322-8453 hille@co.kern.ca.us
Region VI	**Stuart Long** Voice (909) 388-5823 Fax (909) 824-7515 slong@ph.co.san-bernardino.ca.us


Federal Agencies Emergency Support Function # 8
Mutual Aid System Concept
General Flow of Requests and Resources
State Operations Center (SOC)
Medical and Health Branch Coordinators Joint Emergency Operations Center (JEOC)
State Agencies
Other Regions
Regional Emergency Operations Center (REOC)
Medical and Health Branch Coordinators
Regional Disaster Medical and Health Coordinators and Specialists (RDMHS)
State Agencies
Indirectly Affected Local Governments In O.A.
Operational Area
OA Emergency Operations Center (OA EOC)
Medical and Health Operational Area Coordinator (MHOAC)
Indirectly Affected Operational Area
Local Governments In OA
Directly Affected Local Gov't and Hospitals/Clinics
Medical and Health System
EVENT

Acknowledgements

The Emergency Medical Services Authority would like to thank the Disaster Exercise Planning Group members for their contribution to the 2006 Statewide Medical and Health Disaster Exercise Guidebook and planning process.

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Part 2:

Toolkit for
Exercise Coordinators

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Preparing the Materials

Compile, at a minimum, the following materials:

- Statewide Medical & Health Disaster Exercise Guidebook – this document - for November 2006 from the Emergency Medical Services Authority (www.emsa.ca.gov) focusing on the following:
  - Exercise Objectives (*page 13 - 22*)
  - Background Scenario for Exercise (*page 25*)
  - Exercise Day Scenario (*page 27*)
  - Intent to Participate Forms (*page 45*)
  - Conducting the Exercise: Tips for Hospitals (*page 79*)
- Messages developed from the scenario and the "shake map" impact projections (see reference *page 88*) to provide to the participants within the EOC and messages for the ACS* groups within the OA.
- A list of key contact information for participants and government organizations.
- Critique forms developed by the organization and the "Hotwash/Debriefing Form", (*page 124*).

Issues for the Medical/Health Community

The following list has been created as potential issues for inclusion or consideration in planning the exercise:

1. Patient Movement/Patient Tracking
2. Resource Allocation
3. Austere Care
4. ACS*
5. Staff Movement to/from both "Directly Affected" and "Indirectly Affected" areas
6. Volunteer Staff
7. Oxygen Surge
8. Medical Supply/Equipment Shortages
9. Internal Communications (both tactical and strategic)
10. Inter-Discipline Coordination
11. Structural Integrity
12. Loss of Infrastructure
13. Handling and Storage of Human Remains
14. Corporate Assistance and Coordination within the SEMS process
15. Public Information Officer (PIO)/JIC
16. Security/Law Enforcement
17. Non-Medical Needs (water, ice, food, shelter, etc.)
18. Mental Health

Coordination with Other Organizations

The 2006 exercise focuses on the medical and health system as it responds to a major Bay Area earthquake and a terrorist-detonated IED event in San Bernardino County. The background scenario sets the stage of events leading up to the exercise. The medical and health system must respond to an overwhelming influx of patients and shortages of resources including staffing, supplies, equipment and blood products, as well as the need to evacuate facilities and transfer patients to new areas throughout the State. The scenario is designed to facilitate relationship building between healthcare facilities and the governmental organizations responsible for assisting in the location and supply of necessary resources.

Coordination with the Media

Collaborate with the local agencies'/departments' PIO to define how the media will be addressed during the planning process (media or press releases), during the exercise (press briefings and conferences, written risk communication messages), and post exercise (communicating the success of the community-wide exercise). Prepare media releases in advance and sound bites can even be pre-recorded. For example of Public Service Announcements and Media Advisories, see *page 43*.

Coordination with ACS* Staff

In order to enhance the exercising of ACS* staff and integrate ACS* more closely into the exercise, two-way messages will be sent to and from the following: Facility to/from "Directly Affected Area" OA; "Directly Affected Area" OA to/from REOC. OES will assist with the coordination of ACS* play during this activity. A list of all OES ACS* contacts can be found on *page 109* of the Guidebook; you are encouraged to make contact prior to the exercise and plan the activities. Note in the Exercise Guidebook that all facilities are encouraged to review their policies and procedures for authorizing and sending messages.

If there is an actual emergency during the exercise play, a message, "TIME OUT- All Transmissions Must Stop!" will be repeated three times and all ACS* traffic will cease.

Scheduling Personnel, Space, and Equipment

- It is recommended that facility and organization staff assigned to the exercise are notified well in advance to coordinate their schedules and plan for participation. For critical exercise positions or assignments, consider scheduling back-up staff that are also briefed and trained prior to the exercise.
- Announce the exercise date on local agencies/departments calendars, in-house publications or computer schedules so all involved personnel save the date when they are scheduling other activities.
- Identify and reserve the exercise location/space before the exercise.

- Assess the exercise area to make sure construction or other changes do not hinder the layout for performance of the exercise, e.g., removal of the phone lines from the room, or removal of the chairs and tables.
- Develop a checklist of the equipment you will need to support the exercise.
- Check all equipment for proper functioning and operation before the exercise.

Developing Local Scenarios

The scenario in the 2006 Statewide Medical & Health Disaster Exercise Guidebook details a sequence of events to be used by participants. This sequence provides the overall anticipated schedule of activities that all participants can incorporate into the community exercise. Local agencies and departments may plan an extended exercise scenario or alter the scenario to meet the needs of the OA or organization. Local agencies/departments will decide the scale and intensity of participation and their role in transmitting information from the healthcare providers to the OA Medical/Health POC.

To assist hospital participants in planning and executing a facility-wide exercise, please see Conducting the Exercise: Tips for Hospital Participants, *page 79*.

Planning Controller and Evaluator Roles/Functions

Each OA or Facility participating in the exercise needs to coordinate and staff their own Controller and Evaluator roles/functions for the exercise.

Reporting Intent to Participate

Each participating entity should notify the OA Exercise Contact of its intent to participate and complete the Intent to Participate form (*see page 45*). The participating entity should FAX the Intent to Participate form to the OA Exercise Contact by **September 15, 2006**. Upon receipt of the forms from each individual facility, the OA Exercise Contact will compile the participant totals on the OA Intent to Participate form (*page 46*).

The Exercise Contact will FAX the OA Intent to Participate form to the RDMHS no later than Friday, **September 22, 2006.** (See *page 111* for the listing of RDMHS contact and fax numbers). The RDMHS will FAX these sheets to EMSA, c/o Anne Bybee by **Tuesday, September 26, 2006**.

Recommended OA Primary Contacts and Participants

- Each OA Exercise Contact is strongly encouraged to coordinate with the following entities within the OA no later than September 22, 2006 to ascertain their participation in the exercise:
- Hospitals and clinics
- Ancillary healthcare facilities (skilled nursing facilities, other care facilities)
- Ambulance Providers and Emergency Medical Services
- Local Public Health Department
- Local Emergency Medical Services Agency
- Local Office of Emergency Services
- ACS* providers
- Medical and Health OA Coordinator (MHOAC)
  NOTE: Many of the MHOACS will continue exercise play after the hospitals end. They will continue working with the RDMHC/RDMHS and EMSA in the allocation and prioritization of resources.

Exercise contact phone number lists should be developed within each OA and Region, an effort coordinated by the Exercise Coordinators and the RDMHS.

1. Each entity participating in the exercise is encouraged to designate a representative to liaison with the OA Exercise Contact and attend meetings in preparation for the exercise.

2. The Exercise Contact is encouraged to conduct at least two (2) pre-exercise, preparatory meetings with the participants within the OA to:
   - Determine level and scope of agency and OA participation and collaborate on the development of community specific scenario events based on the statewide scenario.
   - Provide participants with phone numbers to reach the OA Exercise Contact on the day of the exercise, as well as relevant fax and e-mail addresses.
   - Inform participants of potential conflicts or competing activities that may occur that day.
   - Review Emergency Management Plans in preparation for the Exercise.
   - Communicate procedures to terminate the exercise both within the OA and within each participating entity, should an actual emergency occur during the exercise. Many agencies use the term “time out” to stop exercise play. (This is different than the instruction on *page 122* to terminate the exercise for an actual emergency in that it is usually used to indicate a non-emergent stop in the exercise play.)
   - Identify where and how information is to be communicated within participating organizations during the exercise, and how it is to be marked, e.g., “This is a Test,” “This is a Drill,” or “This is an Exercise.”

- Identify the person (or agency) that will enter information into RIMS during the exercise.
- Invite other participating agencies, departments or organizations to briefings or training for the exercise.
- Contact and update other agencies, departments or organizations about any last-minute changes in participation or communications.
- Assist the participants in finding community volunteers to participate in the exercise to increase realism in the play.

Other Recommended Contacts and Participants

Expanding the exercise in the OA is strongly recommended and encouraged. The following entities should be considered for involvement in the exercise, if possible:

- Metropolitan Medical Response System (MMRS) (if applicable in the city/OA)
- MRCs
- CERTs
- Local law enforcement and Federal Bureau of Investigation (FBI)
- Local fire departments
- Local schools and/or school officials (even if only in a tabletop)
- Medical Examiner (Coroner)
- Environmental Health
- Public Utilities
- Others as identified by the scenario or the unique OA entities
- Others as identified in the Emergency Management Plan

Pre-Exercise Survey of Resources

Changes often occur at the last minute and can interfere with a successful exercise. Organize a team of "checkers" who do nothing more than check facility readiness, materials, storage lockers, phones, fax machines and other communications systems the evening before and the morning of the exercise.

Briefing of Participants

Provide the participating staff job action sheets, background information, organizational charts, pertinent policies and procedures and role expectations before the exercise begins to increase participant comfort level and exercise success. At the minimum, the organization should be aware of the exercise in progress.

During the briefings, and throughout the exercise, it is very important to stress that this is **only an exercise** to all participants and agencies/departments. Written materials and scripts should denote and emphasize this is only an exercise. Oral communications and instructions should reinforce the "exercise" status. This is a learning opportunity for the staff, the facility/organization and local government and can assist in assessing the effectiveness of the emergency management plan(s) and identify areas for improvement.

Terminating the Exercise for an Actual Emergency

Should there be a need to stop or "pause" the exercise due to an actual emergency situation or event, the State Exercise Control Cell will notify the RDMHS to terminate the exercise. The State Exercise Control Cell will give a "**Terminate the Exercise**" order and the exercise will be immediately terminated at the State and regional level. Each OA Exercise Contact will be notified by the RDMHC/S to terminate the exercise.

It is recommended that the OA Exercise Contact **and** each participating organization establish a similar "Terminate the Exercise" command in the case of actual emergency or safety issue.

Reporting Situation/Status Information to the OA

Each participating agency will compile situation and status information utilizing their own OA forms and submit reports to the OA officials according to OA policies.

The participants will begin transmitting their situation/status reports to the OA by 0600 on the day of the exercise (see the exercise scenario).

Critiques and Reporting

NOTE: Participants in the GGEX06 exercise may have separate guidance or requirements for post-exercise Hotwash, After Action Reporting, etc. and should contact their GGEX06 coordinator for more information.

Exercise debriefings should be conducted by each participating agency and a community-wide debriefing scheduled and conducted by the OA Exercise Contact. To assist the debriefing, there is an After Action Review (or debriefing points) on *page 124* to assist in the evaluation of the exercise. This information will also be needed for the regional and state After Action Review.

Considerations for debriefings include:

- Announce the debriefing meeting in advance of the exercise to facilitate participant attendance and preparation for the meeting.
- Distribute the debriefing points in advance of the exercise to allow meeting participants to prepare critiques.
- Hold debriefing meetings in a convenient location in the community.
- Act as the facilitator and allow the participants from government and private sector organizations to discuss the successes, challenges and needed improvements identified during the exercise.
- Take meeting notes to be provided later to all participants as a feedback mechanism, including those participants who could not attend the critique.
- Consolidate feedback and submit to EMSA (c/o Anne Bybee, anne.bybee@emsa.ca.gov or FAX 916-323-4898) by December 11, 2006.
- Develop a list of improvements needed and action items into three categories:
  - Short Term (less than six weeks to accomplish)
  - Mid Term (up to three months)
  - Long Term (greater than three months)
- When possible, organize a work group to follow-up on the action items over the next three months,
- Remind exercise participants to complete the exercise evaluation answer sheets to receive a Certificate of Participation (see below).
- End the meeting on a high note and thank participants for their participation.

After Action Review

This is a suggested list of questions recommended for incorporation into the debriefing or After Action Review for the exercise participants. Please elicit as much detail as possible and compile the information. The questions posed here deal with the Guidebook, the Communications systems and RIMS.

It is recommended to appoint one person to conduct the debriefing and to moderate as required. A scribe can be directed to track and document comments and recommendations made by the participants during the After Action Review. The OA Exercise Contact, or designee, should compile and submit the information to the RDMHS during a regional After Action Review to be announced at a later date.

It is suggested to schedule the OA debriefing as soon as possible after the exercise or no later than December 8, 2006.

Debriefing Questions

Evaluation questions specific to the facilities or exercise entities can be found in the Exercise Evaluations, starting on *page 47*. Add to that the following:

1. Was the information contained in the Disaster Exercise Guidebook clear and concise? What changes/additions are suggested? Do you recommend keeping this as one document or returning to the two separate documents (Guidebook and Toolkit)?

2. Was the "Intent to Participate" form user friendly? Would you suggest any additions or deletions?

3. Were the "Exercise Objectives" clear and applicable to a potential real life situation?

4. Was the "Exercise Scenario" realistic, useful and clear?

5. Did you change or expand the exercise scenario to meet the needs of the facility? If so, how?

6. What items/sections of the Disaster Exercise Guidebook were not helpful?

7. Any suggestions for improvement in any of the items or sections of the Disaster Exercise Guidebook?

8. Were the pre-exercise time frames/expectations reasonable? What would you do differently?

9. Did you utilize the "Sample PIO Media Advisory? Was it worthwhile having as a reference in the Exercise Guidebook?

10. Did you test communication systems?

    a. Did you use an alternative communication system during the exercise (i.e. ACS*)?
    <u>If yes</u>:

        i. Describe the benefits and/or problems with data transmission via ACS* radio.
        ii. Were two-way messages sent and received?
        iii. Was the specific information requested from hospitals, ambulance providers and others useful?
        iv. What would you add/delete?
        v. How would you resolve any problems or issues in the future?

    b. Did you use other communication technologies during the exercise (i.e. fax, email, internet, etc.)?
    <u>If yes</u>:

        i. What were the benefits and what worked well?
        ii. What did not work well, what problems or issues did you have?
        iii. How would you resolve any problems or issues in the future?

11. Describe the use of the RIMS in the county.

    a. Where and by whom was the information entered into RIMS?
    b. Was the information requested from the hospitals pertinent to the situation and helpful to you?
    c. Will the overall Medical/Health information requested on the RIMS forms be pertinent in a real life situation?
    d. What suggestions would you offer for revisions to the Medical/Health RIMS data?
    e. What training, administrative or logistical issues need to be addressed?
    f. If the OA's EOC was activated:
        i. Was the interaction with disaster management officials at the OA's EOC useful and provide you with direction, information and assistance?
        ii. Describe the interaction with the EOC in the OA.
        iii. What worked well?
        iv. What could be improved?

Participant Recognition and Certificates

After the exercise, Certificates of Participation will be issued to all exercise participants who meet the exercise criteria found on *page 10* and upon completion and submission of the Exercise Evaluation forms to EMSA.

Certificates of Leadership for Exercise Coordinators

After the exercise, Certificates of Leadership will be issued to OA or Facility Exercise Coordinators who meet the exercise criteria found on *page 9* and upon completion and submission of the Exercise Evaluation forms to EMSA. Please note the request to receive the Leadership Certificate (versus Participant Certificate) in the cover letter when submitting the evaluations.

RIMS: Tips & Considerations for Government Response Agency Use Only

*Note: It is very important that the "**training**" section in RIMS is utilized to enter data during the exercise. When RIMS is accessed, be sure that you are in the TRAINING SECTION before data entry.*

RIMS is an Internet based information management system and consists of a set of databases designed to collect information on the disaster situation, communicate action plans and receive mission requests. RIMS is accessed and utilized by OAs, regional and State governmental agencies.

RIMS Access Issues

- Established RIMS users have a password into RIMS and will log onto RIMS using their individual assigned access and password.
- The **RIMS Situation AND the RIMS Event Reports** will be entered into RIMS before the exercise by the State Exercise Control Cell, and should not be re-entered by the OA or local governmental agency. This will ensure that all RIMS entries will be entered into the disaster exercise fields.
- Please enter RIMS information only under the ***Status Report*** Field, not the Event or Situation report field.
- The Event is named: ***2006 Medical and Health Disaster Exercise***. It is very important to enter the OA RIMS information under this event name and not a similar exercise/event/name. Do not create a new name for the exercise, but enter all data under this event name only.
- On the day of the exercise, the OA will enter information into RIMS at the following intervals:
  - Enter an initial status report **within 30 minutes of the beginning of the exercise**, or at approximately 0545. This initial report is a "snap-shot" of the status of and critical issues confronting the OA.
  - Update and modify the initial report as additional information or resources are requested.
  - Enter final exercise status information obtained from participants beginning at 1100 or later, compiling the information and reporting aggregate data.

Essential Initial Status Information for RIMS

Hospital Status (RIMS Status Report Number 8.b.)

- Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- Overall Medical/Health Critical Issues (RIMS Status Report Number 19)
- Bed Availability (RIMS Status Report, Bed Availability, Resources Available)

Expanded and Ongoing Status Information for RIMS

Hospital Status (RIMS Status Report Number 8.b.)

- Bed Availability for the next 8 and 24 hours (RIMS Status Report, Bed Availability, Resources Available)
- Estimated Casualties: Major and Minor (RIMS Status Report Number 7.a and b.)
- Status of SNFs, clinics and/or Field Treatment Sites (RIMS Status Report Number 9)
- Medical/Health Critical Issues (RIMS Status Report Number 19)
- Medical mutual aid needs for personnel, supplies and transport (RIMS Status Report Number 10)